ONTARIO

PROVINCE OF ONTARIO

2 Commissions and committees of inquiry?

THE MEDICAL SERVICES INSURANCE ENQUIRY

PROCEEDINGS OF THE PUBLIC HEARINGS HELD AT THE COUNCIL CHAMBERS, CITY HALL, WINDSOR, ONTARIO, AT 10.00 A.M. ON WEDNESDAY, DECEMBER 4th, 1963.

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Mr. A. ROY COULTER
Dr. JOHN HAMILTON
Mr. W.J. MAJOR
Miss HELEN McARTHUR
Mr. T.J. MULROONEY
Mr. CARMAN A. NAYLOR
Mr. HARRY SIMON
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G/dpw

--- On commencing at 10:00 a.m.

SUBMISSION OF THE RAILROAD HOSPITAL ASSOCIATION

Appearances: O.A. Derrough
L.R. Hoag

THE CHAIRMAN: Good morning, gentlemen.

Members of the Enquiry have received and studied the brief you submitted. In accordance with the guide for participation in hearings that was mailed to you, it will not be necessary for you to read your brief, but you do have an opportunity to emphasize or enlarge upon its conclusions or recommendations.

Members of the Enquiry may ask you questions on the statements or recommendations submitted in your brief, but you are not to be subjected to examination or cross-examination by other persons.

It is not our intention to debate your suggestions or recommendations, nor to state the views of this Enquiry on them. Consequently, any opinions expressed in questions asked or statements made by members of the Enquiry are intended for clarification only.

As stated in the instructions, one person is to act as your spokesman. However, if the spokesman feels that another member is better qualified to answer a specific question from a member of the Enquiry, the spokesman may

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receive the Chair's permission to request the other member to answer.

Will you please identify your spokesman, and then proceed.

The members of the press have requested a copy of your brief, and if you have copies with you, perhaps you will hand them to the members of the press at the conclusion of your submission.

MR. HOAG: I understand that we are not supposed to read this brief, because it has already been presented; is that right, sir?

THE CHAIRMAN: That's right, yes.

MR. HOAG: I think I might say this, that perhaps our position might be just a little different than some other open insurers, and that has been brought to my mind here this morning, I believe, by Mr. Whitney, that we are a closed organization, and I think what he means by that is that our coverage is open for railroad employees only, and I have brought that up in my brief -- would it be necessary for us to accept anyone who wants to get into our Association? With that in mind, we are not here so much to offer any advice. We do feel this, that there are a number of advantages by way of standardization of contracts, and so forth, by having a Committee of this nature, and also a set-up, and we're very pleased to see that the Ontario Government is allowing the

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insurers to carry on under their jurisdiction. We think that that's a better way of handling it than for the Government to take over entirely.

Of course, we have a little selfish interest there, too, because if the Government takes over entirely then we're out, and we're not in the business to make a profit, we are in for the benefit of our members, and our members want us to continue, if we can. If the O.H.S.C. took over, we're out.

We cover private and supplementary, which, of course, you aren't interested in, but we try to continue with as many of our benefits as we can.

I read in last night's paper where the Windsor Medical is to present a brief this morning, and mention was made that they have been pioneering for 25 years. Well, we're over 70 years old, and as far as we know we are the oldest organization in the field.

That doesn't mean that we know more about the business. We know what we're doing ourselves, and we haven't been interested in what the other people are doing, but now we have to be interested in it, whether we want to or not.

We've told you in our brief pretty well what our position is, and we're here to find out more how we can fit into the picture, and if we have to be open to anybody who wants to get into our Association, or whether we can still keep

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it as confined to railway employees.

That's about all that I have to say about it, and, of course, we'll be interested in entering into any discussion that might come up, sir.

THE CHAIRMAN: Thank you, Mr. Hoag. Some of our members have indicated that they would like to ask you questions.

However, I would like to make a statement relative to one statement that you made there, and that is that the members of the Enquiry at this time aren't in a position to tell you how you can fit into it, or how you can't, or what our ideas are as to how you will fit into it. These are things that we will be considering previous to making up our report.

MR. HOAG: I had a separate recommendation that wasn't included in the brief, and I forgot to say anything about it. I think that after this organization gets set up, and gets going in practice, that it would be a good idea to assign certain agents, or somebody from the Board, to go around and interview personally each one of the organizations, and see that their set-up conforms, because we had some difficulty with the O.H.S.C. I mean, we didn't get any personal assistance in the thing. We had to sort of work it out ourselves, and I think it would be to the advantage of everybody if somebody would come down to us and say, "We would like to

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look over your system and your records, and see what you are doing," and say, "You can do this and you can't do this and so forth, and you will have to make certain changes." I think that would be very important.

Are those the kind of recommendations you are after, sir?

THE CHAIRMAN: Any recommendations you like to make would be quite in order.

MR. MAJOR: Good morning, Mr. Hoag. I was very interested in your brief, particularly because it includes only railroad men, and I gather this would include any railroad employee, whether it is the running trades, the non-running trades, or the shopmen, and so on?

MR. HOAG: Well, it does, to a certain extent. Actually, our Constitution allows us to take anyone along the line or right-of-way of the New York Central Railroad, or any other railroad that has running powers over the New York Central Railroad in Canada; that is the Canadian division between Detroit and Buffalo, or any railroad employee who resides in an area where it is considered to be within our jurisdiction.

MR. MAJOR: Does this include C.P.R. and C.N.R. employees?

MR. HOAG: It would, yes, providing that they are residing, or working, in our area. One wouldn't want to

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MR. HOAG: It would, yes, providing that they are residing, or working, in our area. One wouldn't want to

look after anybody in Saskatchewan, or British Columbia.

MR. MAJOR: You stated, sir, that your organization had its beginning possibly 70-odd years ago. Did it have its beginning here in Canada, or is this a New York Central proposal from the States?

MR. HOAG: It had its beginning right here in Canada, and how this happened is rather interesting. This is history. I know you will be interested in it, but the railroad men, especially the train men, used to get together and find somebody would be sick, and they would take up a collection and give them some assistance, and somebody came up with an idea that if they would pay so much a month, then they would have a fund that would take care of people who needed assistance through illness, and that was really the starting of the organization.

MR. MAJOR: Very interesting. On page 2 of your brief, paragraph 4, you put forth here a basic principle of anti-selection in insurance, and it is well put, and I was wondering does your plan, when you take on a new subscriber, have any particular waiting periods, or deterrents, for immediate coverage?

Or, when you take this subscriber on, are they covered for whatever your coverage includes?

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family assistance has to wait two months before the benefits, but the members themselves, as soon as we take them and they are accepted, they are covered. We start from the 1st of any month.

MR. MAJOR: Have you got a particular waiting period, say, for confinements?

MR. HOAG: Yes. We do. We have a ten-month waiting period.

MR. MAJOR: From the time that the family is accepted?

MR. HOAG: That is right.

MR. MAJOR: But no other waiting periods for the employees themselves?

MR. HOAG: Well, we have a waiting period for hernias of ten months, and also a ten-month waiting period for ailments of the female genitary system, and tonsils and adenoids.

MR. MAJOR: Are female employees eligible to join?

MR. HOAG: They are, but it's a little different set-up than the male members. We carry them under what we call the family group plan. Actually, the two things are sort of separated, because we have looked after the men for years and years before we took the females in, and there seems to be quite an objection amongst the male employees to take females in. However, that's one of the things that competition brings

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to the fore, because we found out that when other insurers are giving that protection, well, we just have to give it, because eventually the members want it, and, of course, the members have the say as to what they want.

THE CHAIRMAN: Mr. Hoag, do you have the conditions for insurance for your Association in printed form?

MR. HOAG: Yes, we do.

THE CHAIRMAN: Possibly if you could leave that with the Secretary that would take care of questions such as this.

MR. HOAG: Yes. This is a supplement to our Constitution, and it takes care of all the conditions.

THE CHAIRMAN: Mr. Simon, do you have some questions?

MR. SIMON: On the line of Mr. Major's question on your recommendation 4 on the last page of your brief: you suggest that it wouldn't be fair for a person to wait until he is sick, and then apply for insurance, and so on and so forth.

Now, what is your position with regards to people that drop out of your trade, or your industry, or retire? Do you still maintain him on your list?

MR. HOAG: Yes, we do, and we found out that we had to, because -- at one time we didn't, but the New York Central in this last few years have reduced their staff to a considerable extent. They are only operating, I would say, not

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more than half of the employees that they used to, and some of those members had belonged for years and years, and it didn't seem fair after all those years, when maybe they couldn't get anything to take its place, that they should be required to drop out. So we have been allowing them to continue as long as they can keep their payments up, but, of course, if they drop we can't take them back, because they aren't railroad employees at the time, unless they come back to work again.

MISS CARPENTER: We were wondering when you examined Bill 163 did you feel that on the basis of this Bill you could continue to operate medicare insurance, or did you feel you would have to go out of business if Bill 163 were passed?

MR. HOAG: Well, it was our hope that we could continue in business, and, of course, in looking over the Bill there were certain portions of it, for instance, such as I brought out in this brief, that might require us to take anyone who wanted to come in, and that's the point that we wanted to sort of get some definite information whether in our case we were maybe a little different than anybody else. I suppose everybody feels the same way: "Well, my case is a little different," and, of course, we're taking that attitude, that maybe it is, and at our meeting with the Board of Directors it was definitely stated by our Directors that we wanted to stay in business, and we're willing to comply with regulations,

those members had belonged for years and years, and it didn't seem fair after all those years, when maybe they couldn't get anything to take its place, that they should be required to drop out. So we have been allowing them to continue as long as they can keep their payments up, but, of course, if they drop we can't take them back, because they aren't railroad employees at the time, unless they come back to work again.

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just whatever we have to do, why, we'll go along with it.

MISS CARPENTER: This was the main point you found difficult to accept, the number of persons you would have to insure?

MR. HOAG: Well, for instance, if we had to take an outsider who had nothing to do with the railroad at all, well, that would put us in a lot different position than we're in at the present time.

MR. MULROONEY: Could you tell us, Mr. Hoag, whether your Association is incorporated, legally?

MR. HOAG: Well, now that goes back so far that I would almost have to look into the back records, really.

No, we never have been licensed by the Insurance Department, and I don't know why, but we never have been. We have never been asked to be licensed, and I suppose the reason for that is because -- we've had dealings with the Insurance Department. They know we exist, and all that, but we've never been required to be licensed, and they've never had any jurisdiction over our benefits or premiums, and I suppose that it's been the thought, "Well, this is a railroad outfit, and they're running their own affairs," and I would say now under this new set-up that we're out of that jurisdiction, and we're definitely under control of the new government-sponsored plan.

MR. MULROONEY: It appears that you're operating pretty much as a friendly society.

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MR. COULTER: If a person leaves the district and has been a contributor of yours for a number of years, can he still stay covered in your group?

MR. HOAG: Yes, that's right. We have allowed them to continue as long as they were members, but we felt actually that we would be getting into trouble with the Insurance Department if we took in persons who weren't connected with the railroad service at all, but we thought that it was only right that once they became members they should be allowed to continue, because a lot of those men didn't leave the service because they wanted to, but because of a reduction in staff, and so forth.

MR. WHITNEY: There's no drop-out age at all, then? If they retire at 60 and they live to be 80 and pay their premiums, they would still stay in the plan?

MR. HOAG: We have 150 widows that were left, and they come in and keep up their premiums, and they're the best payers we have. They always keep their premiums up.

MR. CASWELL: Do they pay the same premium, or is there an increase when they leave the railway?

MR. HOAG: No, we always charge the same, and at one time we felt that the younger employees coming in would help to keep the older ones, but now we're all in the older age group, but we still have a pretty good set-up, and the members are quite satisfied with it, and we do want to

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continue with it if we can.

MR. WHITNEY: Do you work on an annually balancing budget, an annual assessment basis to balance your budget, or do you maintain somewhat of a reserve?

MR. HOAG: Well, we have a reserve. Our reserve -- as I said, we operate actually the family group as a separate unit to the members' group, and we do that because some members don't have their families covered, and they thought at the time when the women and children come into this they're going to put us on the rocks, so we insist that they pay their own way, so, on paper, we have operated them as two units; the family unit and the members' unit.

MR. WHITNEY: What I'm leading up to is this, something that you have touched on, and that is that the Bill as it now stands calls for licensing of all carriers who would be involved in issuing standard contracts. I suppose under licensing there may be certain minimum requirements by the Superintendent of Insurance. There may be certain information required, basic information, and proof of observance of standard contract requirements.

Does this bother you at all?

MR. HOAG: Well, the only way that it bothers us is that, supposing the Superintendent of Insurance said, "Well, you are out because you aren't complying with all the regulations of the Act"; we wouldn't mind if he would say,

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"Well, in order to bring yourself in a position where you can continue you will have to meet certain requirements," and we would be quite willing to do it, and that's one reason why we're here. A lot of people don't know anything about us. As you say, we're closed, and working on our own, but we're quite willing to do what we can to work with anybody else.

MR. WHITNEY: Do you issue any sort of financial statement to your members every year?

MR. HOAG: Yes.

MR. WHITNEY: So that that much information is made public, in a sense?

MR. HOAG: What we do, instead of operating on a budget, we go by our last year's financial statement, and we keep a record of each classification of coverage, and we know whether one classification is going behind, or going ahead, and so forth.

In this last year we had what we call a basic coverage, which is for the members, and it's pretty hard to keep it balanced financially, because, well, we cover so many things. I mean, it's such a broad coverage, with so very few limitations, so we did establish a policy during the year that if any one group would go behind a thousand dollars we would put on a dollar-a-month assessment until that was made up, and it's working out very well.

That's another thing, of course. We don't know

"Well, in order to bring yourself in a position where you can continue you will have to meet certain requirements," and we would be quite willing to do it, and that's one reason why we're here. A lot of people don't know anything about us. As you say, we're closed, and working on our own, but we're quite willing to do what we can to work with anybody else.

MR. WHITNEY: Do you issue any sort of financial statement to your members every year?

MR. WHITNEY: So that that much information is made public, in a sense?

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whether we will be able to carry that on after the Government supervision comes into effect. We would like to do it, because it keeps our dues down to a minimum.

MR. WHITNEY: Do you have a first-dollar coverage? Is there any co-insurance, or deductible?

MR. HOAG: No, we don't have any deductible.

THE CHAIRMAN: Questions like that might be answered in the regulations that we have.

MR. WHITNEY: I see what you mean, Mr. Chairman, but not having seen them I would hate to let them get away without finding these things out if they aren't in the regulations.

In the event that your employee lapses his coverage by non-payment, do you have a reinstatement period?

MR. HOAG: The way we operate is this, that a member's dues are supposed to be paid, and if they aren't paid he doesn't get benefits, but we can't suspend him for six months, although he is still not beneficiary, and in order to get back into benefits he has to pay his back dues and if he is over two months in arrears, then we can go back 15 days, and chop this off what he had beneficiary for.

I think you'll find this in almost any insurance, that they wouldn't come in and say, "I want to resign." You just don't see them. We notify a member every month if he is in arrears, so that actually if he gets suspended it's his own

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I think you'll find this in almost any insurance that they wouldn't come in and say, "I want to resign." You just don't see them. We notify a member every month if he is in arrears, so that actually if he gets suspended it's his own

fault.

DR. GALLOWAY: How many people are there insured, and to whom do you pay the benefits, the patient or the doctor; and on what basis are the medical expenses paid; and is there any income protection in your benefits?

MR. HOAG: We have no income protection. What was your first question?

DR. GALLOWAY: To whom do you pay the benefits, the patient or the doctor?

MR. HOAG: Well, we like to pay our benefits right to the doctor.

Now, so far as our members are concerned, we pay the full coverage, O.M.A., whether they go to a specialist or who they go to, but as far as the family group is concerned, when we took that over we kind of profited by experience in operating something that there is no limit to at all. It's pretty difficult to try and carry on financially if you haven't got a limitation any place. So we do make a certain allowance. We have two family groups, and one of them is allowed so much for surgery, and so much for other things, you see, and then we pay according to that, and if they have a second operation for the same thing, then we allow them two-thirds of what we would ordinarily allow for the first one, and so forth.

DR. GALLOWAY: Is that described in this little pamphlet?

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MR. HOAG: Yes, it is. There's only one thing that there has been a little change in respect to that, that we used to allow so much for the first, and two-thirds for the second, and one-third for the third, so we changed that, and instead of that we pay our full allowance for the most expensive operation, and then the next most expensive we pay two-thirds, and then the next most expensive we pay one-third, and then after that we're not responsible.

So there is that little change in there. We felt that sometimes the first operations are the least expensive, and the member wasn't getting the full benefit in that way. So we see that we pay for the most expensive coverage in full.

DR. GALLOWAY: Are you referring to one, two and three under a single hospital admission, or throughout the course of the year?

MR. HOAG: Well, we go by ailments, actually. There isn't any limitation by the year, but there is limitation on each ailment.

We have medicine, by the way, and we have a limitation there, too, and we have to keep a record of that, because I read in the paper where you are a little interested, or not interested -- I don't know which -- in the medicine angle, and I would say that it would be an awfully good thing to steer clear of, because it's really a headache, but, at the

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same time, it does a service to our members, and I think that they really appreciate what we're trying to do for them.

The only thing is that when we come to the end of the period that we can pay, or the end of the limitation, then, of course, you run into a little difficulty, because they object to maybe the fact that they have run their course, but we explain to them, "Well, that's only for that ailment now. If you have another ailment, you're still allowed to draw on that."

THE CHAIRMAN: I believe Dr. Galloway asked how many members you had.

MR. HOAG: Well, we're operating now on about 900 members. That's just about half of what we had, say, about ten years ago, but it's all in view of the fact that we have made so many reductions in the staff.

Those are actual members, and in addition to that there are about two-thirds of those members who carry their families.

Then, as I told you, we have about 150 widows that we carry as well.

DR. BUTT: Mr.Chairman, I would like to congratulate Mr. Hoag. I think he has certainly shown us perhaps the reason why we're here. In other words, 75 years ago you started to do something that maybe we're starting to do now, and in the light of that I want to ask you this.

You've read the Bill, and does this make it

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You've read the Bill, and does this make it

almost impossible for you to operate if you conform to the selling of the standard contract?

MR. HOAG: No. We feel, actually, that our coverage is pretty broad, and I don't feel -- well, we might have to cut off some limitations, and that's one thing, of course, that I would like to know just whether it will be possible to have any kind of limitations at all. I'm not just sure of that.

There are some things that we're not a hundred per cent sure what they mean.

DR. BUTT: Could you make it available to other people? In other words, universally available. Could you still operate?

MR. HOAG: Other than railroad employees, do you mean?

DR. BUTT: Yes.

MR. HOAG: Well, we discussed that, and, of course, when we're limited to just railroad employees we don't have a chance to expand the way we should be able to, and it's just a question of perhaps we might be better off if we have it open for everyone, and I suppose we could if we had a charter to continue under those bases, but it seems to be the feeling amongst the members that they would just like to keep their Association to themselves, if they can, but if they can't, well then, we're willing to comply with whatever regulations

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there are. DR. BUTT: What percentage of those who might be eligible in your Association are now paid-up members?

In other words, you say there are 900. Is there a potential of, say, 2,000, or something like that, or would you know?

MR. HOAG: Well, of course, we make our collections by the month, and I would say that -- oh, I don't imagine that there would be any more than maybe 10 or 15 members at the present time who would be delinquent.

DR. BUTT: Well, really, what I'm asking is, are there a great number of people who could be members of your organization who aren't?

In other words, who are railroad employees but aren't members.

MR. HOAG: Well, of course, you see we've been up against this sort of problem, too, but all the non-operating crafts on the railroad have a blanket coverage through the Travelers' Insurance Company, and that's compulsory, that's a part of their working agreement, that they have to have it. So we just lose a lot of members in that way.

Then, down around Windsor you have the Windsor Medical, and that's a local thing, which is very good, and appeals to a lot of people in this area.

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belong that don't, but it isn't compulsory. I mean, it's optional. They don't have to belong.

DR. BUTT: I realize that.

MR. HOAG: Does that answer your question?

DR. BUTT: Well, more or less, yes. Some of them have other coverage is what you are saying?

MR. HOAG: That's right.

MR. SIMON: Do your members have other medical coverage, or is this the only coverage that they have?

MR. HOAG: Some of them have, yes, and that's another problem, too, but it's my understanding that after this new plan goes into effect, that although I imagine it will be like the O.H.S.C., that if you want to carry two or three insurances, that's your business, but you can only collect on one, and I think that will make some difference, probably, in our membership, too, because a lot of the ones who have been covered under the Travelers', they don't mind being covered under the Travelers'. They can't help it. They have to be, anyway, because it's part of their working agreement, but when the time comes to retire, they don't want to have to keep up the premiums that they would have to pay, and the reduced benefits, too, at the time of retirement. Therefore, they have been keeping up the Railroad hospitalization for the fact that maybe in a few years they would be retired, and they would stay with us, and drop the other.

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We have under consideration at the present time that possibly we might, where there is other coverage like that, we might give protection that would have nothing to do with any of the double coverage features, and allow them to continue at a minimum rate to be members, and at the same time they would be beneficial under certain categories that would have no duplication aspect.

DR. GALLOWAY: Have you come to any conclusion what those other areas would be?

MR. HOAG: No, we haven't, actually. We have, oh, written down a few things like maybe dental care, and chiropractic care, and osteopaths, and maybe medicine might be one, because Travelers' don't carry any medicine, and as long as we're in that line, anyway, well, perhaps we could carry on and make up some kind of a contract that they could be covered under until the time that they are retired, and then we would agree to accept them for full coverage.

MR. CASWELL: Does your Association now cover dental and chiropractic care?

MR. HOAG: No.

MR. CASWELL: You would consider that for the future?

MR. HOAG: No. That was in answer to a question what we might consider covering. Those are fields that could be explored, and we might do something about it.

MR. WHITNEY: Mr. Chairman, if I may say something, and be careful how I say it, I think it is only fair to

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MR. WILLMER: Mr. Chairman, if I may say something, and be careful how I say it, I think it is only fair to

indicate to Mr. Hoag that as the Bill is now proposed, it is in its second reading, it is not final. It does suggest that there is a standard contract with minimum coverages, and certain standard conditions, somewhat the same idea as the standard conditions in a fire insurance policy.

You were worried about minimum coverages, and what you could do about it. This suggests a bottom in the type of coverage, and the conditions of the standard contract, with the right to offer all the frills above, the frills being elected, and the suggested idea of the standard being obligatory. The waiting periods, and all these things, would be uniform under this Bill, as proposed.

MR. HOAG: Yes.

MR. WHITNEY: You are aware of that, are you?

MR. HOAG: Yes, and we think actually as far as our members are concerned, we are fully living up to our requirements now, and more than that as far as that goes, but as far as the plan was concerned, we never have felt like taking over the home and office calls, but now we realize that we have to give that coverage if we are going to continue.

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MR. WHITNEY: Yes, and it also implies here that there will be, the suggested Bill implies that there will be a maximum premium for the standard contract, above which you can't go for standard coverage, but which you can compete, premium-wise, below the maximum.

You are aware of that?

MR. HOAG: But you have to guarantee that premium rate for the first year; is that right?

MR. WHITNEY: Well, it has two years now, with review suggested in two years after experience is gained, and so on.

MR. HOAG: Well, would you consider -- I don't know whether I should ask you this -- what would you consider that our present method now, would it be acceptable just at the present time, that we operate on our present schedule, with the understanding that if any group goes behind that we can put on a special assessment to make that up?

THE CHAIRMAN: I am afraid an answer on that might be accepted as a ruling, which we wouldn't want to indicate, I think, would we, Mr. Whitney?

MR. WHITNEY: I would stay away from that, Mr. Chairman.

I'll just say that you are probably not alone in the situation, and this problem is going to come up again, and sooner or later the Committee is going to have to deal with

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it.

MR. MAJOR: Mr. Hoag, forgetting the assessment, what is your base rate now for the single male employee?

MR. HOAG: Three dollars a month, and that gives him the use of the doctor, and ambulance, and out-patient hospital service, x-rays, laboratory service.

MR. MAJOR: And it covers home and office calls?

MR. HOAG: It does.

MR. MAJOR: What is your rate, then, for the family?

MR. HOAG: We have a rate of $1.75 for what we call the D-2, and then we have another class, D-1. That's a dollar-and-a-quarter a month, and then we charge extra for children up till 16. We allow the children to continue as long as they're dependent on their parents. Sometimes it doesn't work out, because we have no way of finding out sometimes when they become independent, and sometimes they're married, and they're married for two years, and in that case, of course, we feel that our Constitution covers it, because we tell them that they can't continue after they are married, and we refund the money that has been taken on behalf of those people.

MR. MAJOR: These rates are in addition to the $3 that you are collecting from the employee?

MR. HOAG: Yes.

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MR. MAJOR: And it doesn't cover home and office

calls for these dependants?

MR. HOAG: That's right, it doesn't, nor medicine. We don't allow any medicine for the families.

DR. BUTT: Mr. Hoag, would you have any idea of your percentage, say, over 65 and under 65?

MR. HOAG: Well, I would say -- could I give you a guess?

DR. BUTT: Yes.

MR. HOAG: We don't know that exactly, but I would say that over-65's would comprise about a third of our membership.

MR. SIMON: Have you still got some of the original ones?

MR. HOAG: No. I can remember when we did. No. I've been with this organization since '28. That's another reason why I hope we can stay in business, for a while.

MR. DERROUGH: We had a hospital association in St. Thomas before there was a hospital.

MRS. AYLEN: Had your Association anything to do with the establishment of the hospital in St.Thomas, and do you have any representation on the Board?

MR. HOAG: No, we did used to have a kind of an agreement with the hospital, and we have what we call a railroad ward in St. Thomas, but inasmuch as the hospitals, actually most of them aren't paying their own way, and the City had to

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make up any deficit that they had.

They didn't feel that we should have any consideration over and above any ordinary person, and therefore we didn't feel that we cared anything about maintaining a ward. It wasn't our furniture, anyway. We did have furniture in the very first hospital that was there, and what happened to it when the hospital was dismantled nobody knows.

MRS. AYLEN: It was probably worn out.

MR. HOAG: I don't think it would be any use now.

MISS McARTHUR: Do the rates rise rapidly as this proportion of over-65 grows?

It seems to me that this must have happened in the last few years. Have you noticed a marked problem in rate structure?

MR. HOAG: Yes. Well, you see, in industrial work usually the younger people get laid off, and I think that's wrong. It should be the older people, and put on pension, but just the same ---

MR. SIMON: I'm glad you made your last remark.

MR. HOAG: But I think that younger people who are raising a family, and maybe buying their home, need their job more than maybe the older people, who are more or less established, provided the older people are sure of some kind of separation allowance, and in the railroad service they do have. This is a United States railroad, and if you are

make up any deficit that they had.

They didn't feel that we should have any consideration over and above any ordinary person, and therefore we didn't feel that we cared anything about maintaining a ward. It wasn't our furniture, anyway. We did have furniture in the very first hospital that was there, and what happened to it when the hospital was dismantled nobody knows.

MRS. ASKIN: It was probably worn out.

MR. HOAG: I don't think it would be any use now.

MISS MACMURCHY: Do the rates rise regularly as this proportion of over-65 grows?

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unemployed you entitled to consideration from the Railroad Retirement Board.

THE CHAIRMAN: I gather that the questions are exhausted. Thanks very much, gentlemen.

MR. COULTER: Is anyone living in the United States covered under your plan?

MR. HOAG: Yes, we do have some people who have moved to the United States, and what we do, we tell them that we will give them the same coverage there as we would here, and we know that the medical services there are much more than they are here, but just the same they are paying the same money, and if they pay their premiums in United States money, we pay their bill in United States money, but if they don't, why, we just issue a cheque on our bank account, and it's a question between the person who gets the cheque and the people who owe them the money.

When the P.S.I. -- I don't know whether we have any right to discuss another plan or not, but we're all in the same boat here, apparently. The doctors allow 10% reduction from the fee, and they will accept that in full payment, and we think that's kind of unfair competition. We feel that if we're all in this together, and we're supposed to pay the fees, why should not everybody pay it?

Dr. Butt probably might be able to answer that.

DR. BUTT: Did you say I might be able to answer

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MR. WHITNEY: Do you agree with that, Dr. Butt?

DR. BUTT: Well, I would be committing myself, wouldn't I?

THE CHAIRMAN: As I stated at the beginning, we're not here to debate these issues.

MR. HOAG: Well, I hope you will record that as a question coming from our Committee.

THE CHAIRMAN: Thank you, gentlemen. I believe that your organization could very rightfully be called a friendly society.

MR. HOAG: Thank you very much.

THE CHAIRMAN: Is Dr. Peterson present?

SUBMISSION OF CHARLES T. PETERSON, D.D.S.

Appearance: Dr. Charles T. Peterson

THE CHAIRMAN: Dr. Peterson, were you here when I read the instructions to the first delegation?

DR. PETERSON: No, sir, I wasn't.

THE CHAIRMAN: I would like to draw them to your attention.

Members of the Enquiry have received and studied the brief you submitted -- this is the original one. The second one hasn't been submitted. I received that, of course, only the other day. In accordance with the guide for

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So you may proceed.

DR. PETERSON: Dr. Hagey, members of the Commission: the brief I present is that I believe that oral diseases are an infective mechanism. We have certain proof now. More research has to be done, and I believe that we should have a medical approach to oral diseases.

I think the oral health services should not be a technical service, but should come under a medical health plan for the Province of Ontario. Now, I have certain articles here to back up the idea of oral services, in which Dr. Hamilton, Dr. Galloway and Dr. Butt would be very interested. I have also got certain ones that have to do, more in layman's terms,

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with the different problems. I feel that a technical service would not answer the problem of dental care in the Province of Ontario.

Here is a brief note from Dr. Cox of the Children's Hospital:

> "When one considers how frequently systemic diseases, whether due to infection, defective nutrition, hormonal imbalance, blood dyscrasia, or simply old age, are accompanied by distinct pathological lesions within the oral cavity, particularly in the gums and the supporting tissues of the teeth, one wonders why every physical examination does not include a report of the findings in these supporting tissues."

Then I have other things to point out in terms of dental services. This is a copy from the Minister of Health in London England, comparing 1959 and 1960 dental treatments. The number of teeth extracted in 1960 was 11,033,000 teeth; that was permanent teeth. There were 23,000,000 fillings done and there were over two and a half million dentures made in London England. That was just England and Wales.

We have different reports here. It was the Carnegie Report that was done in 1926 -- the Giles Report. I haven't got the latest one on the Council of Education that was just made.

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We have different [illegible]. Carnegie Report that was done in 1925 -- the Gies Report. I haven't got the latest one on the Council of Education that was just made.

But I feel that oral disease is an infective disease, that by research there is no reason why we cannot find out what is causing it and have control. This is not just periodontal disease. I believe that tooth decay is also and that you cannot treat the tooth only -- it must be the tissues as well.

THE CHAIRMAN: Thank you. The members of the Enquiry may have some questions.

DR. HAMILTON: Dr. Peterson, your brief covers a very wide field: medical education, research, the theories and the cause of oral disease, dental practice and prevention. But I would ask you if you would explain what the relevance of this to Bill 163 is?

DR. PETERSON: In essence -- I am sorry. What is Bill 163?

THE CHAIRMAN: This is the bill that we have been charged to investigate with people who have an interest in it, relevant to medical services insurance. It has been placed before the legislature of the province and it has had two readings and that is the sole purpose of this Enquiry.

DR. PETERSON: I am sorry. I feel that the treatment of oral diseases should be approached from a medical treatment of the disease and it should come under medicare plans.

DR. HAMILTON: You are asking then that dental

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DR. HAMILTON: You are asking then that dental

treatment should be included in the medical services made available under Bill 163?

DR. PETERSON: Yes.

DR. HAMILTON: Thank you very much, Dr. Peterson. I have no further questions.

THE CHAIRMAN: Do any other members of the Enquiry have any questions?

Thank you very much, Dr. Peterson.

Is the delegation from the Podiatric Society present? Is the delegation from the Southwestern Ontario Podiatric Society not present?

Is the delegation from the Kent Medical Society here?

Is there anyone here who wishes to be heard?

Let us recess for ten minutes.

---Short recess.

THE CHAIRMAN: Is the delegation from the Southwestern Ontario Podiatric Society present? Would you like to come forward to the table, please.

SUBMISSION OF
THE SOUTHWESTERN ONTARIO PODIATRIC SOCIETY

Appearances: R. J. Tolbert, D.S.C.
G. J. Courey

THE CHAIRMAN: Gentlemen, I will read the

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DR. HAMILTON: Thank you very much, Dr. Peterson. I have no further questions.

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THE CHAIRMAN: Gentlemen, I will read the

instructions which are read to all delegations appearing before the Enquiry:

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As stated in the instructions, one person is to act as your spokesman. However, if the spokesman feels that another member is better qualified to answer a specific question from a member of the Enquiry, the spokesman may receive the Chair's permission to request the other member to answer.

Would you tell us now which one is to the be spokesman?

MR. COUREY: My name is Courey. I am a solicitor.

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Would you tell us now which one is to be

MR. COURTEY: My name is Courtey. I am a solicito

I have with me Richard J. Tolbert, who is a Podiatrist practising in the city and I think there may be some questions more beneficially answered by him.

THE CHAIRMAN: Thank you. Would you like to proceed, Mr. Courey.

MR. COUREY: Mr. Chairman and Members of the Enquiry: First I would like to thank you for the opportunity of appearing here and presenting this brief today and I would like to thank Mr. Turner, the Commission Secretary, for his assistance in supplying us with information necessary for the preparation of the brief which we have before you today.

Now, it is our respectful submission that the public interest cannot be other than very well served by including podiatrists' services under Bill 163.

I must confess personally that until becoming involved in this matter, my own knowledge of this field was very negligible and, frankly, from discussions with many others, I think we can draw the conclusion that the public knowledge of the merit of their work is somewhat superficial. I fully appreciate the commission, likely before this date, and certainly is by this time, very well acquainted with the podiatrists' work and service and his qualifications.

Without going into any detail, I would however like to deal generally now with the services which the podiatrist performs and the value of the particular service.

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As you know, in Ontario the podiatrist is licensed to treat any ailment, disease or defect of the human foot. The faculties teaching podiatry, which are recognized by the Ontario Board, are staffed with podiatrists, medical practitioners and doctors of philosophy of the basic sciences. Generally speaking, their curriculum consists of a pre-professional course of two years, after Grade 12, or one after Grade 13, and four years professional course.

I will leave with you, if it might be of interest, catalogues from two of their institutions which deal with the curriculum and the faculty.

I think the curriculum was dealt with in the brief submitted by the Ontario Association and we needn't dwell on that point today at all.

Now, in essence, the co-operation of the medical profession in podiatric teaching institutions and the increasing number of clinics established in hospitals in the province -- in Toronto there are two in the Toronto General Hospital, one each in St. Joseph's Hospital, Baycrest Hospital, St. Michael's Hospital and Toronto Western Hospital. In London there is one podiatric clinic in St. Mary's Hospital and here in the City of Windsor at Riverview Hospital, which is a hospital for the aged and infirm person, a clinic has been established and it has had, I am assured, very remarkable success in assisting hitherto bed-ridden patients to become and remain ambulatory.

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We believe that the commendations of these hospitals are adequate evidence of the importance and value of the podiatrist's services. The work of the podiatrist in the treatment of diabetic foot is one area in which his services are extraordinarily important and very beneficial and I would, if I may, leave with the Commission a thesis on the Conservation of the Diabetic Foot, prepared by the Diabetic and Podiatric Clinics of Georgetown University Hospital and the Department of Medicine of Georgetown University. It deals, and it sets out very clearly, with the nature of the service which the podiatrist performs in this area, the co-operation between the medical profession and the podiatrist in this area.

I might also leave with the Commission a brochure of St. Luke's Children's Hospital, which sets out the scope of the podiatrist's practice, the nature of his service and the co-operation between the profession in this area.

If I may proceed to the conclusion of our brief, we quite properly feel that Bill 163 does include medical and surgical care of the foot. It does not, however, in its present form, cover these services if required by a podiatrist who, we say, is legally entitled and licensed under the law, as well as properly qualified, to perform these services. Now, no doubt, in so doing, he is competing, if one would call it that, with the general practitioner; but it seems very unlikely that the legislature intended to discriminate against the podiatrist or

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to confer a competitive advantage upon the physician. Certainly this ought not to be the case and I am sure that the medical practitioners themselves do not seek such an advantage and would not, in good faith, prefer to have it. In many instances, I suspect that the medical practitioner would prefer not to be burdened with treating matters properly within the scope of the podiatrist's practice. Notwithstanding this fact, however, the podiatrist as well as the physician are, in law, authorized to perform this service and it seems, to a lay observer, that they co-operate very admirably in serving the public interest in this regard.

In essence, the privilege of the selection of a practitioner is considered the right of every individual and this is qualified only to the extent that he must select a person who is, by law, entitled to perform the service he is seeking; with the Act in its present form, patients would be required in effect to pay twice for the services of a podiatrist.

Next, insurance premiums or prescriptions, such as the podiatrist's. There would seem to be no reason to suggest that the podiatrist's services not be covered by the proposed legislation and the only thought that we can see in this respect is the possibility of an added cost and our enquiries seem to indicate that such an objection is erroneous. We say: "The coverage of podiatric service would not incur added cost to the plan, as rates are based on benefits for

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conditions and not who shall treat the conditions. This is substantiated by the fact that private insurance plans providing payment for services rendered by podiatrists have not found it necessary to adjust rates nor have the rates of physician sponsored Blue Shield plans in the United States been adjusted when amended to cover the subscriber who elects medical or surgical treatment by a podiatrist." There is no acturial evidence for the Commission in this regard. We did write to podiatric societies in the United States, various states, where their schemes were amended to provide for payment of podiatrists and these indicate that there was no adjustment in the rates charged as a result of the inclusion of their services. I may leave these with the Committee as well.

In addition, there are some 29, I believe, private insurance plans in the Province of Ontario which do at the moment cover and pay for services when rendered by a podiatrist. We have no information and no reason to believe that their rates were ever adjusted by the inclusion of payment of podiatrists.

In summary then, I make these points: (1) There is a demonstrated chronic need for specialized foot care; secondly that the podiatrist is extremely well qualified and, indeed, the only man who specializes in this field. The proposed legislation in this field does cover this type of service. In its present form, it would seem discriminatory in that the service

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if performed by a medical practitions is covered, but not if performed by a podiatrist, even though he is qualified and legally entitled to perform such service. So there is no added cost and it would be both equitable and in the public interest that they be included. To give effect to this, we respectfully submit that the Bill should be amended to define the term "physician" to include a podiatrist. That is all I have to say.

THE CHAIRMAN: Thank you very much, Mr. Courey. Some of the members of the Enquiry have indicated their desire to ask questions of you.

DR. GALLOWAY: Mr. Courey, I imagine that some of the questions that I will want to ask you will deal primarily with the practice of podiatry and it may be that Dr. Tolbert will want to answer those questions. Are there any particular differences in this brief which you are presenting and the brief that will be presented in Toronto by the Society?

MR. COUREY: We felt that there was some different emphasis. Frankly, the brief was drawn and referred to them and so I think there is a very marked similarity between them. We did want to deal primarily with the right of the podiatrist in law to perform these services and on that basis his right to be included in a general plan by the payment of this particular type of service.

DR. GALLOWAY: This is the difference between the

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TORONTO, ONTARIO

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THE CHAIRMAN: Thank you very much, Mr. Conroy. Some of the members of the Enquiry have indicated their desire to ask questions of you.

DR. GALLOWAY: Mr. Conroy, I imagine that some of the questions that I will want to ask you will deal primarily with the practice of podiatry and it may be that Dr. Talbot will want to answer those questions. Are there any differences in this brief which you are presenting and the brief that will be presented in Toronto by the Society?

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two briefs?

MR. COUREY: I think essentially it is no more than a matter of emphasis.

DR. TOLBERT: There is really no difference between the two briefs.

DR. GALLOWAY: How many podiatrists are there in Ontario and how many are there in this particular Society?

DR. TOLBERT: There are 68 podiatrists in Ontario; there are 6 in this Society.

DR. GALLOWAY: In the type of work that you do, a number of you do both office practice and some of you do hospital practice through clinics?

DR. TOLBERT: Yes.

DR. GALLOWAY: What would be the average work day as a podiatrist that you would have?

DR. TOLBERT: We spend about eight hours in our offices, I would say, and then there are house calls and calls of that type.

DR. GALLOWAY: Approximately how many people would you treat in a day?

DR. TOLBERT: I myself have been in practice two years. I would treat, on the average, fifteen patients a day. I would say the established practitioners would treat twenty, twenty-five patients a day.

DR. GALLOWAY: This would be a five-day week,

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DR. GALLOWAY: Approximately how many people would you treat in a day?

DR. TOLBERT: I myself have been in practice two years. I would treat, on the average, fifteen patients a day. I would say the established prescriptioners would treat twenty, twenty-five patients a day.

DR. GALLOWAY: Time would be a five-day week,

as a rule?

DR. TOLBERT: Yes, as a rule.

DR. GALLOWAY: Somewhere then between roughly one hundred and one hundred and twenty-five patients a week?

DR. TOLBERT: That is right.

DR. GALLOWAY: And in a hospital, is this time taken out of your office practice or are you paid for that when you are in hospital?

DR. TOLBERT: In hospital here Dr. Ballard maintains a clinic at Riverview. He goes on Wednesday. He is paid. The exact number of patients he sees per Wednesday, I do not know. I did see one list that had about twenty patients on it.

DR. GALLOWAY: Would he be paid on a fee-for-service basis or a salary?

DR. TOLBERT: He is paid on a fee-for-service basis, by the Sunshine Fund set up by the Ladies' Auxiliary, I understand.

DR. GALLOWAY: Would you in your group, or your practice, be treating any indigent patients?

DR. TOLBERT: Pardon?

DR. GALLOWAY: Would you in your practice be treating any indigent patients?

DR. TOLBERT: Yes, we do.

MR. GALLOWAY: And on what basis, or how do you

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DR. TOLBERT: Yes, as a rule.

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DR. TOLBERT: Yes, we do.

MR. GALLOWAY: And on what basis, or how do you

handle them?

DR. TOLBERT: The patient that obviously cannot pay at all, we just treat without fee. Those patients that have a problem, what I do, or what I think most practitioners do, is tell them what their fee is and tell them that when they can pay us, please do so.

DR. GALLOWAY: On reading through your brief, there are several things that come to my mind and maybe it is just a matter of wording. In the first sentence of paragraph one you have stated:

> "Podiatry is the only area of medical practice which specializes in the treatment of foot disease."

In what sense are you using the wording "medical practice", and in what way do you define that the podiatrist is the only person specializing in foot disease? There are so many areas or so many other people in medicine who, at this moment, are interested in the feet.

DR. TOLBERT: I think we are talking about a total specialist. For instance, the dermatologist would never treat athlete's foot and he is a specialist in skin conditions. The orthopaedic surgeon is a specialist in bone and joint surgery and he would have an interest in the foot, from that point of view. But as a total area specialty, we are the only specialty. As far as medical practice is concerned, podiatry

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is a medical-surgical service and, therefore, we use the term "medical practice".

DR. GALLOWAY: Mr. Courey, on page 2, number 3, in which you have stated that:

"The privilege of selection of a practitioner is one that every individual accepts as his right;"

and then there is the next phrase which says

"...provided, however, that the practitioner he prefers is one entitled by law to perform or render the service needed."

Is that last phrase correct? Could the patient not elect to go to an unlicensed practitioner?

MR. COUREY: I suspect that he would be entitled to go to anyone for any service; but I think not, if he is called upon to use a public plan for the payment of those services. On the other hand, it is very difficult to say that he is even entitled to go to anyone for any service because in some instances such acts would constitute crimes. There are only certain individuals who are licensed to provide medical service or any type of professional service. Their limits are generally defined in law, so that people cannot render, unless they are licensed, a professional service. I think it would then be incorrect to say other than an individual is not entitled, under our system at least, to seek a professional service from a person who is not qualified to give it -- not if

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MR. GOURLEY: I suspect that he would be entitled to go to anyone for any service; but I think not, if he is called upon to use a public plan for the payment of those services. On the other hand, it is very difficult to say what is even entitled to go to anyone for any service because in some instances such acts would constitute crimes. There are only certain individuals who are licensed to provide medical service or any type of professional service. Their limits are generally defined in law, so that people cannot render, unless they are licensed, a professional service. I think it would then be incorrect to say other than an individual is not entitled, under our system at least, to receive professional service from a person who is not qualified to give it -- not if

he is going to be paying for it, and certainly not if he is going to use a public plan to finance it.

DR. GALLOWAY: This is only true if you are speaking of it in regard to medical health insurance, as I think you are in this brief?

MR. COUREY: Yes.

DR. GALLOWAY: I was interested in the fact that you do not think that costs would rise. I wonder if we can ask the Doctor what percentage of your patients pay you in cash and receive reimbursement from the insurance company and what percentage do you think are insured at the present time?

DR. TOLBERT: I would say 95% of my patients are covered by health insurance, the Windsor Medical Services. Windsor Medical Services is a physician-sponsored plan. It does not reimburse them for them podiatric services; therefore, the patients who do pay me -- and it is about 90% -- do pay me in cash. Some people do have private insurance plans along with it. I have not had one private insurance plan that would not reimburse them.

DR. GALLOWAY: If you do have six practitioners treating one hundred people a week, which means about six hundred treatments, what rates do podiatrists charge?

DR. TOLBERT: The fee schedules vary from area to area. An Ontario office call is five dollars. A house call is seven dollars. A hospital call is seven or five. The

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Windsor Medical Services is a physician-sponsored plan. It does not reimburse them for their podiatric services; therefore, the patients who do pay me -- and it is about 20% -- do pay me in cash. Some people do have private insurance [illegible] with it. I have not had one private insurance plan that would not reimburse them.

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surgical fees vary with the services.

DR. GALLOWAY: This means quite a sum of money that must be found someplace?

DR. TOLBERT: It can be quite a burden for some patients and it is.

DR. GALLOWAY: It also could become quite a burden to a health insurance plan.

MR. COUREY: We have tried, as best we can, to determine whether or not the rates would increase. Now, I do not understand the ramifications of this, but I would think that a patient, if covered by insurance, would be somewhat wont to seek attention from a person, even although he might be qualified and entitled to perform that service, if it meant the paying, in addition to his service, a fee to that particular practitioner. In other words, you can't help but draw the conclusion that these people must seek assistance from persons who are covered to do so. In many cases this might be the doctors in this area, particularly where Windsor Medical is the prevailing insurance program. I do not know that the service which the podiatrist performs takes in any area of practice that is not performed by a doctor or medical practitioner. If it is necessary and the patient consults him, I should think that that is precisely where the medical practitioner would handle it. What would happen then is that the patient would always have to go, under this scheme, to a doctor

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or to pay twice. By including podiatrists, the rates have not increased in a number of other jurisdictions, even physician-sponsored plans, which have included them in it. It can only be assumed that this comes about by a change of the practitioner dealing with the service. Some patients, and I suspect to the annoyance of some physicians and to the pleasure of many others, seek this service from a podiatrist but to the insurance company I do not think it makes any difference, if they have to pay for this service, regardless of who they pay.

DR. GALLOWAY: Do you think there would be any greater utilization of the service if it was insured under a medical health insurance plan?

DR. TOLBERT: I think probably there would be, as there has been with all comprehensive insurance plans, such as in Windsor with the Windsor Medical Services. The only thing is I think we would see less of chronic cases and more acute cases and, therefore, treatment periods would actually decline.

DR. GALLOWAY: In your hospital practice, do you work as a practising podiatrist or do you work under the direction of some medical person?

DR. TOLBERT: In the clinic at Riverview Hospital, it has a podiatric clinic and it is just under the general direction of the staff, as all other plans are. When I go into a general hospital to treat a patient, it is always at

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the request of a physician and I never do anything that I have not consulted with him about.

DR. GALLOWAY: Thank you very much, Mr. Courey and Dr. Tolbert. I am sure there will be many other questions that will come up. But you have helped me a great deal.

DR. HAMILTON: Mr. Courey, in item 6 on page 2, I am not quite clear what is meant at the bottom of the page:

> "'physician' means a medical practitioner registered as such under The Medical Act...",

and the next part is what I do not understand --

> "or under the comparable legislation of any jurisdiction outside Ontario in which medical or surgical care or services are rendered to a resident, ..."

MR. COUREY: I do not understand that either, but it was in Bill 163 in that manner and I did not wish to alter it in that section. I only wished to include podiatrists.

DR. HAMILTON: The second part of this, which states "...and for the purpose of this Act" -- you mean Bill 163, presumably -- "the term 'physician' shall include a podiatrist.." Do you mean that there shall be two definitions of physician, one under the Medical Act and one under Bill 163?

MR. COUREY: No. For the purposes of this legislation, a podiatrist acting within the scope of his practice, would be entitled to the benefits which accrue to medical

the request of a physician and I never do anything that I have not consulted with him about.

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MR. COUSENS: No. Now the purposes of this legislation, a podiatrist acting within the scope of his practice would be entitled to the benefits when someone is medical

practitioners or physicians acting within the scope of their practice. It would seem to be the simplest and most clear way. I refer to the more skilled draftsman to deal with this point. Within the scope of their practice, if this service is to be covered, this is on an equitable basis of persons entitled to perform this service and qualified to perform it, and these people are very well qualified. I find myself somewhat surprised at the qualifications. But they should be entitled to be included and the Act is discriminatory to exclude this service if performed by another person who, by law, is entitled to perform it. It should cover the service and not a single profession.

DR. HAMILTON: I have one last question. Where are the faculties of podiatry?

MR. COUREY: There are two: The California Podiatric College and the Ohio College of Podiatry. There is also the St. Luke's, a children's medical centre, the College of Podiatry, the Illinois College of Podiatry and I believe there is one in New York. There are five in the United States.

DR. HAMILTON: Have all of these university affiliation or sponsorship?

MR. COUREY: I believe not. I think many of them started with and are now separate teaching institutions. I do not know that they even all started with -- but they are not today all affiliated with universities.

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DR. HAMILTON: Are any of them affiliated with universities?

DR. TOLBERT: Not at the present time, no.

MR. CASWELL: Mr. Courey, you are really not seriously concerned with having Bill 163 amended to call a podiatrist a physician? I assume what you are interested in is having podiatric services included as far as benefits go under Bill 163?

MR. COUREY: Yes, and included if performed by a podiatrist.

MR. CASWELL: In the summary you are suggesting that the Act would be changed so that the podiatrist actually would be called a physician; but you are not really concerned with that, are you?

MR. COUREY: No, sir.

DR. TOLBERT: There is one thing on that. The reason we chose this wording, and it was largely at Mr. Courey's suggestion, was because this is the wording in the Blue Shield Plans in the United States where they define a physician and then they say: "Within his scope of practice, a podiatrist shall be considered a physician for the services covered under this contract."

MR. WHITNEY: Of course, that is a contract and not a legislative bill?

DR. TOLBERT: That is correct.

DR. HAMILTON: Are any of them affiliated with universities?

DR. TOLBERT: Not at the present time, no.

MR. CASWELL: Mr. Courey, you are really not seriously concerned with having Bill 103 amended to call a podiatrist a physician? I assume what you are interested in is having podiatric services included as far as benefits go [illegible].

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MR. COUREY: I pointed out, from the draftsman's point of view, you will have difficulty in dealing with it in any other way, but we do not object to dealing with it in any other way.

DR. TOLBERT: We are not trying to be called "physicians".

MR. CASWELL: What you actually want is to have your services included in the Act. It would seem very difficult to recommend that the podiatrist should be called a physician.

MR. COUREY: I will leave it with that, except I certainly did not intend that and only where the term is used in this Act, he shall be included, if acting within the scope of his practice.

THE CHAIRMAN: Mr. Major?

MR. MAJOR: I have no questions, Mr. Chairman.

THE CHAIRMAN: Miss McArthur?

MISS McARTHUR: I understood that the delegation was tabling the basis on which the opinion that the objection of rising costs was based. They are going to table the documents on which they base what appears to be an opinion on this, on page 2 section 4. Am I correct, you are leaving the basis on which this is based?

MR. COUREY: I will leave letters indicating that -- and this is all we have -- that the rates have not increased.

MR. COURNEY: I pointed out, from the department's point of view, you will have difficulty in dealing with it in any other way, but we do not object to dealing with it in any other way.

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MR. COURNEY: I will leave it with that, except I certainly did not intend that and only where the term is used in this Act, [illegible] of his practice.

THE CHAIRMAN: Mr. Meisner?

MR. MEISNER: I have no questions, Mr. Chairman.

THE CHAIRMAN: Miss McArthur?

MISS McARTHUR: I understood that the description of rising costs was based. They are going to table the documents on which they base what appears to be an opinion on this, on page 2 section 4. As I correct, you are leaving the basis on which this is based?

MR. COURNEY: I will leave [illegible] that -- and this is all we have -- that the rates have not increased.

THE CHAIRMAN: Are there any other members who have questions?

MR. WHITNEY: Mr. Courey, we have referred to the insurance coverages in the United States. There was very little reference to Canadian coverages. In your research, do you find podiatric treatment covered by the carriers or the insurers in Canada?

MR. COUREY: Yes. There is an appendix to the brief which we submitted and I can leave, again, with you a list of 29 companies in Ontario.

MR. WHITNEY: I remember that now.

THE CHAIRMAN: Are there any further questions?

MR. MULROONEY: On page 5, paragraph 5, you speak of treatment rendered by podiatrists in certain teaching hospitals in Toronto: St. Joseph's, Toronto Western, St. Michael's, Toronto General and Baycrest. Are podiatrists authorized to have patients admitted to those hospitals?

DR. TOLBERT: These are out-patients clinics. We do not have in-patient privileges.

MR. MULROONEY: Could you be more specific about the type of treatment that is rendered in these clinics; just what is done by the podiatrist?

DR. TOLBERT: In most of them -- in fact in all of them, it is the treatment of skin lesions, particularly in diabetic patients, because they have found that with the treatment

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MR. MURROONEY: On page 5, paragraph 5, you speak of treatment rendered by podiatrists in certain hospitals in Toronto: St. Joseph's, Toronto Western, St. Michael's, Toronto General and Sunnyvale. Are podiatrists authorized to have patients admitted to those hospitals?

DR. TORNEY: Wards are out-patients clinics. We do not have in-patient privileges.

MR. MURROONEY: Could you be more specific about the type of treatment that is rendered in these clinics; just what is done by the podiatrist?

DR. TORNEY: In most of them -- in fact in all of them, it is the treatment of ruth lesions, particularly in diabetic patients, because they have found that with the treatm

of these lesions we have prevented ulcerations, gangrene, and amputations. I understand that minor surgery for nails and for corns is also being done on an out-patient basis in at least one of these hospitals.

MR. MULROONEY: In your treatment, do you administer anaesthetics?

DR. TOLBERT: Yes, locally.

MR. MULROONEY: Local anaesthetics?

DR. TOLBERT: Yes.

MR. MULROONEY: Cocaine and that sort of thing?

DR. TOLBERT: Yes.

MR. MULROONEY: Thank you, Mr. Chairman.

THE CHAIRMAN: Are there any further questions? Thank you, gentlemen.

Are the members of the delegation from the Kent County Medical Society present?

SUBMISSION OF
THE KENT COUNTY MEDICAL SOCIETY

Appearances: Dr. A. C. Henderson
Dr. L. J. Shepley
Dr. J. S. Packham

THE CHAIRMAN: Were the members of this delegation present when I read the instructions to the previous elegation?

DR. SHEPLEY: Yes.

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MR. MULROONEY: Thank you, Mr.

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THE CHAIRMAN: Under those circumstances, I will not repeat them. Who is to be your spokesman?

DR. SHEPLEY: Mr. Chairman and Members of the Enquiry: In presenting this brief from the Kent County Medical Society, we do so because we have the feeling that we have had a rather unique experience for the past quite a number of years in that our County has been privileged to share in the development of Windsor Medical Services because very early after its development here in Windsor we became a branch society or a branch of the Windsor Medical Services. This has enabled us, over the years, to have experience with this service type of plan and, at the same time, we have had the opportunity to witness and experience the application of many other types of insurances applicable to medical care. We have had a substantial number who have, over the years, used the services of the Physicians' Services Incorporated in its development. There have been a number who have had Associated Medical Services coverage and, in more recent years, we have been very pleased to see develop the service type of coverage provided through the Kent Medical Co-Operative. During this time it has also been possible for us to extend the application of the indemnity type of insurance coverage so that we feel we have had an opportunity, perhaps, more unique in this area than in any other part of the province, to see all these types of insurances working together. We have drawn certain conclusions from this

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experience and our recommendations, which we have listed in our brief, which we feel is a very brief brief, are detailed there in order.

We would like to emphasize the fact that our brief is not presented with any idea of being in opposition to the brief which would be presented by our parent organization, the Ontario Medical Association, but would be presented to emphasize such aspects of the problems as may be presented in the Association brief and, perhaps, to bring a little different slant on some of the aspects.

Primarily, we have come to feel that the coverage should be based primarily on a service type plan. This has come to be the feeling of physicians who are members of our Kent County Medical Society and I do not feel we need to elaborate too much on our reasons for it, except that we have, in our opinion, found that it seems to satisfy the needs of our patients and the needs of the attending physicians in the best way.

Now, as a sort of basic philosophy, we have developed the idea that in the provision of medical services by insurance, the financial gain by a corporation or carrier providing this arrangement should not be a motivating factor. This is a philosophy which we have evolved, after watching the experience of both our patients and our own profession, in conjunction with the application of the various types of medical

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We would like to emphasize the fact that our brief is not presented with any idea of being in opposition to the brief which would be presented by our parent organization, the Ontario Medical Association, but would be presented to emphasize such aspects of the problems as may be presented in the Association brief and, perhaps, to bring a little different slant on some of the aspects.

Primarily, we have come to feel that the coverage should be based primarily on a service type plan. This has come to be the feeling of physicians who are members of our Kent County Medical Society and I do not feel we need to elaborate too much on our reasons for it, except we have, in our opinion, found that it seems to be satisfy the needs of our patients and the needs of the attending physicians in the best way.

Now, as a part of basic philosophy, we have developed the idea that in the provision of [illegible] by insurance, the financial gain by a corporation or carrier providing this arrangement should not be a motivating factor. This is a philosophy which we have evolved, after watching the experience of both our patients and our own preference, in conjunction with the application of the various types of medica

insurance plans.

Now, these are perhaps the chief recommendations that we would like to present for the consideration of the Enquiry. We have some more or less specific suggestions. We do believe that the coverage should be comprehensive and that Schedule B proposed in Bill 163 be deleted. We have several reasons for that, which are listed. But, primarily, we feel that our experience has indicated that, by and large, there are very few people who, in the long run, prefer to have this type of in-hospital only coverage. We have a feeling that the inclusion in the legislation of this may just simply be a bit of cluttering up of the provision of service which we visualize as being the intent of this legislation.

We have come to feel, on this basis that we have enunciated, that the premium structure should be community rated rather than experience rated and I guess that sort of ties in with our idea that the service plan type of coverage is what we prefer.

We have suggested that there be a three rate premium structure which, I believe there are many others feel should exist, and we have suggested certain specific changes in the Act, which need not be elaborated on.

We have also heard a good deal of discussion relative to the proposal of pooling and it seems to be inferred in the Bill, and in discussion relative to it, that some type

insurance plans.

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We feel that can be a way which would equalize the sharing of the high-cost patients -- and I use the word patients because, after all, it is the individual who counts. We have evolved the actual arithmetical solution for this, which may seem much too simple for the actuaries who might have to actually put it into practice, but we believe, from our experience with management in so many parts of our economy, that management often can be asked to do what seems to be the impossible and they come up with an answer. We think that in actual practice applying the principle of a community rated premium and a single tariff with uniform screening methods for assessing such accounts as may be worked out,

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G/dpw

that the overall cost and the total experience of all the carriers can be summed, and that this corporation, Medical Carriers Incorporated, that is suggested, could be the agent for accumulating these details and assessing them. Then each individual carrier would have its own average cost, its own total cost, and the average cost in a given carrier's experience would vary according to the number of high-cost cases that they might have to actually pay medical bills for.

In others the number, or the proportion of the high-cost cases might be so significantly small that it would appear to be a profit, but actually it would mean that the carriers who had experienced a loss could bill their debits, their loss, to the pool, and the carriers who had experienced a profit could credit their profit to the pool, and then the funds would be distributed in such a way that each one's total cost would be covered.

I may have made this appear too simple, and there may be many questions which would be applicable, but we are of the opinion that any pooling on a pre-experience basis could not but ultimately force all the carriers toward what we have suggested. We might just as well start that at the start, and that's a community-rated premium structure.

I think that's all I have to say, thank you, Mr. Chairman.

THE CHAIRMAN: Some of the members of the

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I think that's all I have to say, thank you, Mr. Chairman.

THE CHAIRMAN: Some of the members of the

Enquiry will want to ask you questions. Miss McArthur?

MISS McARTHUR: I have a very simple one, although it was a question of definition.

We notice you have a similar discussion, No. 16 on the last page, to one which will be presented this afternoon. Since this Item 6 under Schedule A suggests that newborn infants might be exempted, we would like to have your opinion as to why you suggest that this be not included, and I think some of the members of the Committee would be interested in your definition of a newborn infant.

DR. SHEPLEY: Mr. Chairman and members of the Enquiry: we felt that this didn't quite clarify what might be understood in one area, and in other areas another understanding might arise, and so, when you say newborn-infant care, we couldn't just feel that that was clear enough to really have satisfactory meaning, because it might mean in somebody's idea just the in-hospital well-baby care, performed by any physicians, or it might mean the care of a new baby, who is sick during its time shortly following birth, or it might be interpreted to mean the care of the newborn for weeks or months, and specifically also we felt that this might be interpreted to mean that if an obstetrician delivered the baby, and he turned the care of the baby over to a paediatrician, that the paediatrician might be entitled to make a charge for the newborn care, whereas the physician who

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delivered the baby would not be able to make a charge for newborn care, whether it was ill or well.

We felt that it would be better to leave this right out, and it could be an item which could be better arranged for through the Ontario Medical Association's tariff, so that if the time were to arrive when the obstetrical fee should not include the in-hospital immediately post-delivery newborn baby care by the attending physician, it could be so spelled out in the tariff, and to include it specifically in legislation ties the hand of anyone who might subsequently be performing the newborn infant care, it being a problem if such a baby were delivered and there was nobody else to deliver it, and he chose to look after it himself.

MISS McARTHUR: That's a few reasons.

MR. CASWELL: Doctor, you tell us, or it's my understanding, that the Kent County Medical Society is composed of doctors who are practising in the county.

Is there some restriction on a practising doctor becoming a member of the Kent County Medical Society?

DR. SHEPLEY: No, it's a voluntary membership. The members of the Society are those who voluntarily band together to form the Kent County Branch of the Ontario Medical Association.

MR. CASWELL: I'm asking this because it would appear from your brief, and from the information that we have,

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MR. CARMICHAEL: I'm asking this because it would
appear from your brief, and from the information that we have,

that this service has been reasonably satisfactory, so I find it difficult to understand why 25% of your practising doctors would not be associated with your Society.

This seems to be a fairly high percentage of the doctors practising in the county who would belong if there was not something wrong somewhere. You say four honorary members, and you have 70 out of 84 who are practising members belonging to your Society, so in other words, you have 20% that do not belong. You've got 70 active, you say, and you have 14 practising doctors who don't belong?

DR. SHEPLEY: Four are honorary members.

MR. CASWELL: Well, I'm not counting them.

DR. SHEPLEY: The honorary members also practise.

MR. CASWELL: Oh, well, I assumed that they didn't practise.

DR. SHEPLEY: They are honorary members awarded honorary membership in our Society because of long standing, very fine association with our profession.

MR. CASWELL: Well you still have ten who do not belong for some reason or other.

DR. SHEPLEY: Yes.

MR. CASWELL: You are suggesting, in No. 6 on page 6, that the physician and his patient are interested, not in sound underwriting, but rather in giving and receiving medical care, and it would seem to me that both the patient

that this service has been reasonably satisfactory, so I find it difficult to understand why 25% of your practising doctors would not be associated with your Society.

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MR. CASWELL: You are suggesting, in No. 6 on page 6, that the physician and his patient are interested, not in sound underwriting, but rather in giving and receiving medical care, and it would seem to me that both the patient

and the physician have to be interested in sound underwriting, whether this service is going to be paid for by the employer and the employee, or by the patient and the Government, or by the Government itself. Ultimately, the patient and the taxpayer is going to be paying for it, and unless he is interested in the underwriting of the scheme, it isn't going to be very practical, I think.

DR. SHEPLEY: I think that it is most important that one read this in context. We feel that basically the physician and his patient are not interested in the insurance underwriting principle so that a profit can be made. We are interested in sound underwriting so that the arrangements can be made so that both the giving and receiving of medical care, if needed, can be arranged for, and that it can be paid for.

The important phrase there is:

"...so that a profit can be made..."

We, as I said before in my introductory remarks, do feel that the profit motive should not be an impelling aspect of the development of medical insurance.

MR. CASWELL: Of course, this is going to be controlled by the competitive nature of the carrier service. It's going to be a minimum rate, and a competitive service. It's not going to be given by one carrier, and that, to a large degree, is going to control the profit ratio.

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DR. SHEPPLEY: We are interested in sound

underwriting, but not so that a profit can be made by a carrier.

Does that explain our position?

MR. CASWELL: Yes, I know exactly what you are saying, but I don't think that you, as a physician, or I, as a patient, can expect that a carrier is going to provide the service without a reasonable profit. I don't think that's fair to expect.

THE CHAIRMAN: I think that Dr.Shepley has registered his point, and we don't want to debate it.

DR. HAMILTON: Dr. Shepley, there's just one question I have to ask. It's under Item 5 in your recommendations:

"That the totally subsidized should be covered by an extended Medical Welfare Plan."

Would you please tell me why you make that recommendation?

DR. SHEPLEY: We believe that if the state is entering into arrangements for the provision of opportunities for people to have their medical services covered, the cost of their medical services covered, that those who are medically indigent, totally subsidized, shouldn't be in the position that when they are admitted to hospital they should there find themselves in a different position, that they, as they have now, should have their medical welfare coverage, as

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MR. GASWELL: Yes, I know exactly what you are saying, but I don't think that you, as a physician, or I, as a patient, can expect that a carrier is going to provide the service without a reasonable profit. I don't think that's fair.

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through our Medical Welfare Plan, the Ontario Medical Association's through the Department of Welfare, and by extending their benefits to include those of the comprehensive plan in hospital, as well as out of hospital, the individuals then have their medical coverage as private patients both in and out of hospital.

I'm very keenly aware of the problems concerning the teaching hospitals.

DR. HAMILTON: That was really not relevant to my question, Dr. Shepley. My question was really directed towards finding out if you meant by this that the indigent patients should continue to be treated under the Welfare Plan as presently operated by the Ontario Medical Association?

DR. SHEPLEY: I do.

DR. HAMILTON: They would have no choice in regards to their insurance, but they would receive the same benefits, meaning then that the Ontario Medical Association would be operating as an insurance carrier.

Is that what you mean? They would then be in competition with the insurance companies providing coverage under the Act?

DR. SHEPLEY: It's our feeling that the Government felt an obligation for the provision of medical care to the totally indigent, and that over the years this has been done out of hospital

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through its association between the Department of Welfare and the Ontario Medical Association, and that we here in Kent have felt that this has worked very well. We have been under the impression that it has provided an opportunity for the indigent patient to receive medical care, and at the same time the physician to be compensated through the Medical Welfare Plan which is our professionally-administered arm, so to speak, of the Department of Welfare, a department of government, and we just felt that where government was endeavouring to extend the care it may well extend the benefits in its Medical Welfare Plan.

We believe that the Medical Welfare Plan should be continued as the means for the provision, through the Department of Welfare, in conjunction with the Ontario Medical Association, of care of the totally medically indigent.

DR. HAMILTON: But the same benefits would be available to the individuals in the Medical Welfare Plan as those who purchase their insurance plan from some other agency; is this what you mean?

DR. SHEPLEY: Yes.

DR. HAMILTON: Thank you very much.

DR. GALLOWAY: I would like to go one step further, and ask a question of the doctors, whether or not their interest is in the patients receiving the care and that the doctors receive payment for the care.

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DR. HAMILTON: Thank you very much.

DR. GALLOWAY: I would like to go one step further, and ask a question of the doctors, whether or not their interest is in the patients receiving the care and that the doctors receive payment for the care.

What would be the advantage of the Ontario Medical Welfare Plan over some other institution taking over the administration of this, if this was let out on a tender, for example, to one of the major insurance companies, would you have any objection to this?

DR. SHEPLEY: Mr. Chairman, we've felt that experience is a great teacher, and the experience, we believe, of the Department of Welfare and our Association have been extremely satisfactory in the provision of the arrangements for the medical services to the indigents out of hospital, and for the payment for these services by government through the Medical Welfare Plan, and we visualize that this could very well be a means by which government could, on its behalf, most satisfactorily arrange for the extension of the coverage to the in-hospital care of the medically indigent people.

You ask what my opinion would be if they were to sell it out to another carrier. I wouldn't like to see that happen myself, personally. I believe the members of our Society have felt sincerely that the present Medical Welfare Plan has worked so appropriately that we could visualize it continuing to operate appropriately just by extending the benefits.

MR. NAYLOR: Dr. Shepley, you have recommended the service type of plan, on the basis of what you have seen of the operation of service-type plans, and indemnity plans,

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MR. MAYLOR: Dr. Shepley, you have recommended the service type of plan, on the basis of what you have seen of the operation of service-type plans, and indemnity plans,

side by side.

I wonder if, perhaps, you have reached that conclusion because, perhaps, in many cases, a service-type plan is paying the full costs, whereas the indemnity-type plan, in many cases, might be something less than the current scale of fees, and if we had an indemnity type of plan which paid the full current scale of medical fees, would you then still feel that there was any reason for preferring a service-type plan?

DR. SHEPLEY: Mr. Chairman, our experience has been in our county where we have had the opportunity to see a substantial number of people with service plans, and more recently people with indemnity plans, and to practise medicine in that set-up, that we came to the conclusion that people like the service plan way of coverage better, and we like it better.

I don't feel that the actual failure of the indemnity type of plan to cover the total fee was the primary factor in making the decision. The position was more one of ease, and the type of arrangement whereby the patient had really no forms to be taken to the doctor, and no dealings, other than just paying his premium to the carrier.

The whole thing seems to work more than satisfactorily on the basis of the plain service type of coverage, and if we get back to the basic philosophy, which we are

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The whole thing seems to work more than satisfactorily on the basis of the plain service type of coverage, and it we get back to the basic philosophy, which we are

somewhat steeped in here, I believe that was evolved when Windsor Medical began this service type of insurance.

MR. NAYLOR: Thank you, Dr. Shepley. You have suggested that a community rate system should be used, and also a simple pooling method, which, as I understand it, would seem to involve all the insurance being put into the one big pool also. It does seem to me that that kind of a pooling arrangement would work out equitably only if all carriers charged exactly the same premium rates, and I wonder, therefore, if I understand your suggestions correctly, as it seems to me they would involve the regulation of premium rates to the point that all carriers would charge uniform rates, and all competition would be removed.

Is that what you mean by your proposals?

DR. SHEPLEY: Ostensibly it comes down to the belief that the premium charged for the plan provided by a regulation under the Act would be the same charge by all corporations, all carriers, and I think we feel that it would ultimately come to that after experience.

DR. BUTT: My first question had to do with the interpretation of pooling, as opposed to reimbursement, or opposed to re-distribution after a certain length of time.

I presume that after one year, whether you are forecasting or not, you are basing it on the statistics, so that you have your statistics on which the actuarial pooling

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I presume that after one year, whether you are forecasting or not, you are basing it on the statistics, so that you have your statistics on which the actuarial pooling

would be carried out.

The other thing is you do feel that the pooling is, shall I say, something satisfactory, and something worthwhile; is that correct?

DR. SHEPLEY: Prefacing our reply on the philosophy that it's post-experience, not pre-experience, rate.

Pre-experience rating picks out a group, I understand, and says, "These are in experience a high-cost group, so we must put them in the pool," whereas actual experience would make it possible to determine the exact costs of the high-cost groups of people.

DR. BUTT: I think you're saying the same thing. After one year's experience either way?

DR. SHEPLEY: Yes.

DR. BUTT: You dealt with the Medical Welfare Plan, and I'm not quite sure whether you answered Dr. Hamilton's question; namely, could anybody else handle it?

The other point that I wanted to ask you was, do you realize how the Medical Welfare Plan, or can you tell me, receives their payments for premiums, or in lieu of premiums, and how it is distributed to the physician? Can you give me your interpretation of this, and whether this would change the situation, or whether the situation would be changed by this Act if the premiums were paid?

DR. SHEPLEY: Mr. Chairman, Dr. Butt is very

would be carried out.

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do you realize how the Medical Welfare Plan, or can you tell

me, receives their payments for premiums, or in lieu of premium

and how it is distributed to the physicians? Can you give me

your interpretation of this, and whether this would change the

situation, or whether the situation would be changed by this

Act if the premiums were paid?

DR. SHEPPLEY: Mr. Chairman, Dr. Butt is very

cognizant of the way in which the Medical Welfare Plan derives its funds by the Ontario Medical Association negotiating with the Department of Welfare, and arranging for a per capita contribution, a per indigent, to the medical Welfare Plan per month, and on that basis there's so much money put into the fund, and then this is distributed by the Medical Welfare Plan to the physicians who render the service, and the distribution is based on the tariff of the Ontario Medical Association, but not necessarily has it been possible to make full payment for the services on a hundred per cent of this tariff. This has been pro-rated as experience necessitated according to the amount of money which has become available in this Medical Welfare Plan, and one can certainly see the possibility that such a - you can call it premium or per capita contribution, could not be negotiated at such a level as would make it feasible for the profession to continue to participate in the Medical Welfare Plan, and yet we have felt over the years that experience has been such that the Association has been able to negotiate in a very friendly manner with government, and come up with something that was quite reasonable.

DR. BUTT: My question, specifically, I think, was that if the benefits are equal to any other Schedule A which you suggest, and the premiums are changed for that, does this change your thinking?

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DR. BUCK: My question, specifically, I think, was that if the benefits are equal to any other Senegubie A which you suggest, and the premiums are changed for that, does this change your thinking?

DR. SHEPLEY: It doesn't change my thinking.

DR. BUTT: All right. Thank you.

DR. SHEPLEY: I'm happy with the arrangements.

MR. WHITNEY: Dr. Shepley, I first want to state, leading up to my question, as a personal reaction that I have been personally impressed with the amount of medical aid that the profession does give. I think the general public, like myself, doesn't realize the extent of it. I think the medical profession has done an excellent job under the Welfare Acts, there are seven of them listed on the back of the Bill, to extend this medical aid, and there has been some talk, as you have mentioned, about whether this should stay under the Medical Welfare Plan.

Putting the question, I think it's pretty much Dr. Butt's question placed another way, there will be more indigents likely, not created, but found to be included in this plan as it becomes better known, and so on. The accountants have given us some figures that indicate that there will be an increase in the welfare patient.

Are you suggesting that the continued subsidization of this ever-growing group by the medical profession should be continued, or should the premium, however it is collected, whether it is paid out of tax money, or wherever it comes from, should now be raised to the level where subsidization of what the medical profession is doing will be

DR. SHEPLEY: It doesn't change my thinking.

DR. BUTT: All right. Thank you.

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lessened, and these welfare patients' services should be pretty much brought up to the O.M.A. Schedule?

Has this entered your thinking? I just want an expression of your feeling.

DR. SHEPLEY: It has been our feeling that over the years the provision of in-hospital care without charge to the indigent group has not been too great a burden, but we have been concerned about the extension into more and more aspects of our social welfare, and we believe that it should be expected that in the development of the present legislation and its basic principles the coverage for medical compensation should extend in some way.

We haven't been too concerned about the degree. It should extend in some way to take care of medical services in hospital to the totally subsidized group.

MR. WHITNEY: My second question is this: when you suggest the deletion of Schedule B, are you really suggesting we don't need it, and should cover it all under Schedule A?

DR. SHEPLEY: Yes.

MR. WHITNEY: I see. So that whether the services are performed in hospital or out of hospital it would be the same thing?

DR. SHEPLEY: That's right.

MR. MULROONEY: I understand, Doctor, that the

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MR. MULRONEY: I understand, Doctor, that the

Kent County Medical Society is a component of the Ontario Medical Association; is this correct?

DR. SHEPLEY: Yes.

MR. MULROONEY: Can you tell me whether the recommendations, and specifically, the recommendation with regard to the subsidized people, is the policy -- are you expressing, if you like to put it another way, the opinion of the Ontario Medical Association, or are you speaking only for your own Society?

DR. SHEPLEY: Mr. Chairman, can I ask Dr. Packham to reply to that?

THE CHAIRMAN: Certainly.

DR. PACKHAM: You are speaking of Item 5 of the recommendations

MR. MULROONEY: Specifically, yes.

DR. PACKHAM: Well, this is the opinion of the Ontario Medical Association also.

MR. MULROONEY: One further question, Mr. Chairman. I wonder whether the recommendation is based on the idea that medical doctors should be compelled to continue to provide some measure of their services gratis? That is, to accept something less than the present schedule of fees for the care of the indigents.

This is an act of charity. This seems to be implicit in the suggestions so far.

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DR. SHEPLEY: I think, Mr. Chairman, that our reaction to that would be that our first recommendation is the one that we really feel underlines our whole philosophy, that legislation should avoid interference with doctor-patient relationship, and in that relationship there is no compulsion.

MR. MULROONEY: Thank you.

MR. SIMON: Doctor, you speak, in your brief, about comprehensive and extended care. Can you give us a definition of what you mean by comprehensive care? Would that include nursing care, medicine and rehabilitation services, and things of that kind, or is it narrowed to something else?

DR. SHEPLEY: Essentially Schedule A.

MR. SIMON: You're referring to Schedule A of the Bill?

DR. SHEPLEY: Yes.

MR. SIMON: Talking about community pooling, can you visualize the situation where in some centres in Ontario there are a lot of retired people, older people, and if you pool them only on a community basis, you would have a higher cost for their medical care in certain communities, as compared to others where there is an average age group?

DR. SHEPLEY: Just to avoid that problem, we really mean by community rate, community rate is provincial, province-wide.

MR. SIMON: You weren't too clear in the

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DR. SHEPLEY: Just to avoid that problem, we really mean by community rate, community rate is provincial, province-wide.

MR. SIMON: You weren't too clear in the

language.

MISS CARPENTER: Under the Medical Welfare Plan as it is currently operated, does the physician know when he is treating a patient that the patient is medically indigent?

DR. SHEPLEY: Mr. Chairman, yes, we do. Patients come to us and present a medical identification card, or a voucher.

Now, there are many instances when the relief recipient in the local municipality may appear, and not present a medical identification voucher, and we may not know for several weeks, or months, that they have been receiving municipal relief, and that they are entitled to their medical care through the Medical Welfare Plan.

But, by and large, the great majority of these identify themselves with the physician by presenting a medical identification voucher, or card, which we, as participating physicians in the Plan, will sign, and send into the Medical Welfare Plan.

MISS CARPENTER: I was wondering -- a second question -- is it in the best interests of the patient that he is identified as an indigent individual?

DR. SHEPLEY: I think it is.

MISS CARPENTER: Why?

DR. SHEPLEY: There are two reasons. I think that in all of us there is inborn a sense of human charity;

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and the other is that from a practical point of view you just don't send him a bill.

THE CHAIRMAN: I'm sorry. I didn't hear that. From the practical point of view you what?

DR. SHEPLEY: You just don't send him a bill.

MR. CASWELL: Doctor, it has been brought out here that over the years the medical profession have subsidized the welfare cases, and this we know is true, and it's also been brought out that under Bill 163 it's very likely that indigent, or welfare, cases will substantially increase, and if such were the case, and the medical profession were paid 100%, they were not called upon to subsidize, there would be a lot more cases, and they would get 100% fee.

Would this, then, result, do you think, in a lowering of the schedule of fees of the Ontario Medical Association, because of the larger volume paying 100% of the cost?

DR. SHEPLEY: Mr. Chairman, I think we, as a Branch Society, discussed the aspects of this, and I feel it would be a matter which would more appropriately be directed to the Ontario Medical Association when they present their brief.

MR. CASWELL: Thank you.

DR. GALLOWAY: I wanted to make sure that all these recommendations aren't being referred to as those of the Ontario Medical Association, but just No. 5. They aren't

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DR. GAILOWAY: I wanted to make sure that all these recommendations aren't being referred to as those of the Ontario Medical Association, but just No. 5. They aren't

necessarily the recommendations of the Ontario Medical Association.

DR. SHEPLEY: No, none of them are necessarily the recommendations of the Ontario Medical Association, but I think we said in the opening remarks that where they are recommended by other organizations we present them for consideration on their own merit, or to emphasize those presented by any others.

DR. GALLOWAY: Somebody asked the question whether No. 5 was the opinion of the Ontario Medical Association, and I suspect it likely is. I suspect that many of the others aren't.

For example, you've had a very unusual experience, you said, with the service-type plan, and for this reason you've recommended the removal of the Schedule B cases, and in support of this you have made several comments regarding hospitals and admissions in No. 9. In other areas of the province I'm sure there has been a satisfactory arrangement between physicians, patients and insurance carriers who use the indemnity type, and others are only catastrophic coverage, such as Schedule B offers for them, only because they want that particular type, and we don't know, and I'm sure you can't tell us, what that percentage of people is.

Do you think it would be wise to limit the rest of the province in view of your experience here?

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DR. SHEFLEY: No, none of them are necessarily tion.

DR. SHEPLEY: Mr. Chairman, in answer to that we felt that we should present this as our opinion following our experience, recognizing that it would be stacked against the opinions expressed by other areas, and that the Enquiry in its good judgment, would then assess all of these attitudes and ideas, and by so doing come up with what we would, I'm quite sure, feel would be the best after assessing all of these.

We don't believe that ours is the only one. We believe that it should be considered side by side with other briefs, other ideas, other presentations, and from our experience this has been our feeling.

Following assessment of the broad areas of the province, it may very well be that our experience here is not applicable elsewhere, but nevertheless we feel that what has happened should have a bearing on the opinion of the Enquiry in assessing the overall situation.

DR. GALLOWAY: That was very well answered, Dr. Shepley.

The only other point I would like to argue about, again, is this paragraph No. 9, in which you have indicated that pressure would be placed on the doctors, and in (c) the same sort of pressure, I imagine, for out-patient diagnostic services.

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If some plan, or arrangement, for increased

payment for out-patient diagnostic services were developed, would these opinions still hold?

DR. SHEPLEY: I think, Mr. Chairman, the answer to that would depend on -- do you mean increased payment to the physician in attendance, not payment to the hospital?

DR. GALLOWAY: Payment for the services, whatever type they are.

DR. SHEPLEY: To the physician attending the patient?

DR. GALLOWAY: I think one of the reasons, for example, I'm sure you have put this in, is that pressure would be put on you if you had a patient who needed x-rays of the stomach, and those who carry Schedule B would require to go into hospital to have this done.

If, however, a plan were developed in which there were benefits in the plan so that x-rays could be paid for on an out-patient basis, would this not reverse the situation? Would the pressure not be off the doctor to admit the patient into hospital, and would you still consider these arguments valid?

DR. SHEPLEY: By the application of Schedule A it's our understanding that x-rays will be part of the benefits, wherever they were taken, in or out of hospital.

I'm sorry, I just don't follow your question, Dr. Galloway.

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DR. SHEPLEY: By the application of Schedule A it's our understanding that x-rays will be part of the benefits wherever they were taken, in or out of hospital.

I'm sorry, I just don't follow your question, Dr

DR. GALLOWAY: Well, maybe I'm wording it incorrectly, but I'll try again.

At the present moment you have used as an argument for getting rid of Schedule B these pressures that are placed on doctors by patients to admit them to hospital, therefore increasing the demand for beds.

On the other hand, if an insurance plan is developed which allows greater benefits, so that the patients may have out-patient diagnostic services paid for, and still be under Schedule B in the type of insurance that they get, there would be no demand to enter hospital, and they could be done as out-patients.

THE CHAIRMAN: Are we going over things here that will be repeated again in the Ontario Medical Association's brief?

DR. GALLOWAY: I have not seen the Ontario Medical Association brief, sir, and I'm quite willing to drop this point.

THE CHAIRMAN: I don't want to cut off discussion.

MR. WHITNEY: What would you think, just briefly, Doctor, with Schedule B left in, and this is just a shot out of the dark, with Schedule B left in with the patient paying the first week or two?

This is purely a personal question I'm asking

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DR. SHEPLEY: May I answer it personally, then? I would feel that it wouldn't be in keeping with the philosophy of the Bill. I think the Bill's philosophy basically is to try to provide services and payment under the insurance principle, and to have something acting against that would be basically just not in keeping with the aspirations that I believe are included in this Bill.

MR. WHITNEY: It might discourage the over-utilization of the hospital but, as you say, it would be against the philosophy?

DR. SHEPLEY: That's right.

THE CHAIRMAN: Are there any further questions? Thank you very much, Doctor.

We will reconvene at 2 o'clock. We might try to be here about five minutes beforehand, so that we can get started sharply at two.

--- Luncheon adjournment.

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--- Luncheon adjournment.

---On commencing at 2:00 p.m.

THE CHAIRMAN: I think we will start at this time and take it for granted that the other members of the Enquiry will arrive previous to our getting into the substance of that which is to be discussed.

The delegation from the Windsor Medical Services Incorporated is here, I presume. I will read the instructions that have been read to all delegations.

"Members of the Enquiry have received and studied the brief you submitted. In accordance with the guide for participation in hearings that was mailed to you, it will not be necessary for you to read your brief, but you do have an opportunity to emphasize or enlarge upon its conclusions or recommendations.

Members of the Enquiry may ask you questions on the statements or recommendations submitted in your brief, but you are not to be subjected to examination or cross-examination by other persons.

It is not our intention to debate your suggestions or recommendations, nor to state the views of this Enquiry on them. Consequently, any opinions expressed in questions asked or statements made by members of the Enquiry are intended for clarification only.

As stated in the instructions, one person is to act as your spokesman. However, if the spokesman feels that

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As stated in the instructions, one person is to act as your spokesman. However, if the spokesman feels that

another member is better qualified to answer a specific question from a member of the Enquiry, the spokesman may receive the Chair's permission to request the other member to answer.

Will you please identify your spokesman, and then proceed.

The members of the press have requested a copy of your brief, and if you have copies with you, perhaps you will hand them to the members of the press at the conclusion of your submission.

SUBMISSION OF
WINDSOR MEDICAL SERVICES INCORPORATED

Appearances: Dr. E. Durocher
Dr. E. A. Roemmele
Dr. J. R. Barber
Mr. W. V. Walpole

THE CHAIRMAN: Will you please identify now who is to be your spokesman?

MR. WALPOLE: Mr. Chairman, my name is Vern Walpole, Windsor Medical Services. I will act as spokesman for the group here. I would like to introduce at this time on my left our president, Dr. Durocher, on my right, Dr. Roemmele, vice-president, and Dr. J. R. Barber, on my extreme right, also a member of our Board.

THE CHAIRMAN: Will you proceed then, please.

MR. WALPOLE: I would like to say, Mr. Chairman, that we are happy to have this opportunity to present our brief

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to the Committee of Enquiry re Bill 163.

Windsor Medical Services is a pre-paid doctor-sponsored medical service plan, operating in the Counties of Essex and Kent in the Province of Ontario. We have been in operation for a goodly number of years, having received our charter in 1937, and in a relatively confined area in these two counties which, in the 1961 census, represented some 347,645 persons of which our enrolment today embraces some 236,000 persons, or roughly 68-70% of the total population of those two counties.

We are here to co-operate with the Committee. We do not profess to have all the answers. However, we are here to do our best to clarify anything, any statement that we have made in our brief and the recommendations contained therein. We would be quite happy to receive the questions of the members of the Committee.

THE CHAIRMAN: Thank you. Dr. Butt?

DR. BUTT: I might say at the outset that I know a few of the gentlemen on the delegation and have had an opportunity of talking with them before, so I can't feel that I can say any question is personal, but they are not to be taken in that light. I will just ask a few questions. The first one I had, and I think it was asked this morning, was your opinion on Schedule C, coverage outlined in Schedule C be provided through the Medical Welfare Plan. That is in your

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DR. BURT: I might say at the outset that I know a few of the gentlemen on the delegation and have had an opportunity of talking with them before, so I can't feel that I can say any question is personal, but they are not to be taken in that light. I will just ask [illegible] that one I had, and I think it was asked this morning, was [illegible] operation on Schedule C, coverage outlined in Schedule C be provided through the Medical Welfare Plan. That is in your

recommendation number seven, and I believe you probably heard the questions this morning. Would you have anything further to say about this?

MR. WALPOLE: Our recommendation number seven reads:

"That coverage for those persons outlined in Schedule C be provided through the Medical Welfare Plan."

I think perhaps that might be taken in two stages. First of all, just to glance over those seven acts, I believe, outlined in Schedule C, you will note that we are dealing with a particular segment of our population which, in my opinion, is rather unique in this respect that there is a goodly measure of disability embodied in the very nature of these Acts: The Blind Persons' Act, the Disabled Persons Act, the Old Age Assistance Act, the Old Age Security Act, the Rehabilitation Services Act and purely from that consideration only, I would like to first put forward the thought that the seventh recommendation that one carrier only provide coverage for this segment of our population; then coming down to the fact that we have recommended that the Medical Welfare Plan remain intact, I think it is important to recognize the fact that over the years there have been fairly firm lines of communication established between the Medical Welfare Department of the Province of Ontario and the Medical Welfare Plan operated by the

the questions this morning. Would you have anything further to say about this?

MR. WALPOLE: Our recommendation number seven

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Then we have the changing complexity in this particular group of individuals because today they may be eligible for coverage under some of these Acts and tomorrow they are not. So it is in a state of flux. Therefore, to put this out into a multiple-carrier area or to a carrier who is not fully conversant with the ramifications of what goes on in this particular group, such as the administration of the Medical Welfare Plan, it would seem to me to be breaking new ground. And that leads me into the other thought, that in breaking new ground here we would have the people who have been covered for home and office care only. They have received all the medical care; they have not been denied that. I am talking only of the economics of it at the moment. I mentioned earlier that inherent in this thing, there is a certain amount of disability. So here again we are breaking new ground and, in doing so, I feel that there may be some necessity for an underwriting type of contract, such as was discussed here yesterday in one of the other briefs, and if there is going to be an underwriting type of contract, I would say then it would be much better for the medical profession to have that under their control.

DR. BUTT: Thank you. I wondered, in recommendation number eleven, can you amplify it slightly? In other words, I am not quite sure I understand what you mean that only

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DR. MUIR: Thank you. I would, in response
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those persons or "from those persons only who are without coverage at the initial enrollment period or any subsequent open enrollement period."

MR. WALPOLE: Bill 163, at the moment, makes no provision for a carrier to decline an application. This, in a sense, takes some of that away; however, it does not eliminate or preclude a person having a choice of carriers. I think it can be safely said that any carrier who has seen fit to carry a person in a group for a period of time must bear some moral responsibility for the continuation of the coverage of that particular individual; that that being the case, then he should bear the responsibility of providing coverage for the person when he terminates his group coverage and he may apply to the incumbent carrier for continuation of a standard medical service contract. However, he may also apply to any other --- Pardon me. May I back up just a moment. It must be mandatory on that incumbent carrier to accept his application. However, he can then go out on the open market and seek any other carrier, but there would be no compulsion on the part of a given carrier to accept that application.

DR. BUTT: To clarify it, you mean he would have double coverage?

MR. WALPOLE: It could be possible that he would -- could have double coverage until he had fulfilled his late enrolment waiting period and then he could drop one or the

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other.

DR. BUTT: Going on to page 2, Schedule B, I think this was discussed to some extent this morning. As an alternative, I think you said Schedule B is a catastrophic type of insurance, and I think one objection to it is, I believe, that it produces a greater push on the beds and the utilization of beds as opposed to the schedule, which does not?

MR. WALPOLE: That is true.

DR. BUTT: Suppose you had a really catastrophic situation in which your first two weeks in hospital did not count -- in other words, only the patient who is going to be in hospital for two or three weeks or more; would this be a relatively low premium to perhaps look after just the catastrophic situation? Have you any comments on that type of thinking?

MR. WALPOLE: I would say that that would have somewhat of an effect on the demand by the patient of his physician.

DR. BUTT: The point is that the first two weeks would be of no use to him; he has got to be in there longer than that?

MR. WALPOLE: I am sorry. I have one point of clarification. Are you talking of hospitalization or are you talking of the medical aspect?

DR. BUTT: I am talking of the medical aspect

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MR. WALPOLE: I am sorry. I have one point of clarification. Are you talking of hospitalization or are you talking of the medical aspect?

DR. BUTT: I am talking of the medical aspect

pure and simple. This is what the Bill is dealing with. It is going to be the true catastrophic situation that you are talking about.

MR. WALPOLE: Then if I interpret your question, Dr. Butt, this individual having no medical coverage during that period, ten days or two weeks -- no medical coverage during that period of time ...

DR. BUTT: Well, this is not quite right. I guess we will have to get down to an example. I am thinking of the patient that is going to have a long-term illness. Where are you going to define it? In other words, they are going to have to be in hospital for a long time -- and nothing else?

MR. WALPOLE: I think before I could answer your question ...

DR. BUTT: I know. You would have to know exactly what I had in mind?

MR. WALPOLE: That is right.

DR. BUTT: This primarily was the patient who would be in hospital for a long time and unless it was of that type or nature that would require this patient to be in hospital for a long time, there would be no medical coverage?

MR. WALPOLE: I would make only one comment: That is the fellow who is there the eleventh day, he should have been discharged on the tenth day, he would still put

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MR. WALPOLE: I would make only one comment: That is the fellow who is there the eleventh day, he should have been discharged on the tenth day, he would still not

pressure on to be there for the eleventh day in order to get the whole thing paid.

DR. BUTT: Thank you. You answered it very well.

MR. NAYLOR: Mr. Walpole, on page 8 of your brief you suggest, at the bottom, a revision of Section 5 of Bill 163. And I think in answer to one of Dr. Butt's questions you explained the reasons for the second part of it, and I can quite appreciate them. That is where you have a person leaving a group, it seems quite reasonable that it should be the responsibility of the carrier that he has been with in the group to give him a continuation of coverage. However, I am not quite sure that I understand the implications of the implications of the first section or the reasons for it. It seems to me that the effect of it is that during the initial enrolment period, carriers will be required to offer the standard plan only to those who have no coverage at all. If that is the intention, I just wonder why you think they should not be required to offer the standard plan to those who might have a limited form of coverage -- something less than the standard plan?

MR. WALPOLE: I think this could lead to a degree of anti-selection. The person who has been covered by a limited type of program and perhaps he is in that unfortunate position of having to require a great deal of medical care, for which he

pressure on to be there for the eleventh day in order to get the whole thing paid.

DR. BUTT: Thank you. You answered it very well.

MR. MAYNOR: Mr. Walpole, on page 8 of your brief you suggest, at the bottom, a revision of Section 5 of Bill 163. And I think in answer to one of Dr. Butt's questions you explained the reasons for the second part of it, and I can quite appreciate them. That is where you have a person leaving a group, it seems quite reasonable that it should be the responsibility of the carrier that he has been with in the group to give him a continuation of coverage. However, I am not quite sure that I understand the implications of the implications of the first section or the reasons for it. It seems to me that the effect of it is that during the initial enrolment period, carriers will be required to offer the standard plan only to those who have no coverage at all. It that is the intention, I just wonder why you think they should not be required to offer the standard plan to those who might have a limited form of coverage -- something less than the standard plan?

MR. WALPOLE: I think this could lead to a degree of anti-selection. The person who has been covered by a limited type of program and perhaps he is in that unfortunate position of having to require a great deal of medical care, for which he

was not covered under the limited type of program, then as soon as you open that up, all these people are naturally going to gravitate into the other areas, which causes a certain degree of anti-selection.

MR. NAYLOR: Well that is a possibility; although I suppose it is not any more likely to happen there than in the case of a person who has no coverage at all. Furthermore, as you probably know, one of the basic ideas of this whole plan is that coverage is to be universally available and I just wondered if the government would feel that it was doing what is intended if the persons who have some kind of coverage, and that may be substantially less than the standard plan, would not be given the right to get a standard plan?

MR. WALPOLE: I would have to agree that there is some element of freedom here.

MR. NAYLOR: Would you have any great strong objection, or do you see any strong objection to leaving Section 5 as it was, insofar as the initial enrolment period is? In other words, that any carrier that is operating in the field will have to offer the standard plan to anyone in less than the enrolment period, whether they have coverage or not?

MR. WALPOLE: I still wonder if this would not eventually right itself and I think we have to clarify two things here. One is that there are two types of coverage available to citizens of the Province of Ontario on a routine

available to citizens of the Province of Ontario on a routine things here. One is that there are two types of coverage eventually right itself and I think we have to clarify two

MR. WALPOLE: I really wonder if this would not than the enrolment period, whether they have coverage or not? field will have to offer the Treasurer plan to anyone in fear is? In other words, that any carrier that is operating in the Section 5 as it was, insofar as the initial enrolment period objection, or do you see any strong objection to leaving

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basis; one being on a group basis, the other being on an individual basis. And I think if this is the particular type of program which I am talking about here, first of all, as I understand Bill 163, it is primarily geared to the individual, rather than to a group. It seems to me that the fellow who is going to be upgraded will be more likely to be these in a group than perhaps in the individual categories and this might have the effect of upgrading coverage in groups, if what we have proposed here were to remain intact.

MR. NAYLOR: I do not believe I understand your point. You say this might have the effect of upgrading the coverage in a group?

MR. WALPOLE: Yes. Generally, the urging comes from the people who are covered under the group. Not too often the group itself desires this; it is the urging of the participants in that group and if enough people in that group urge upon his or her employer to upgrade their coverage, simply to take advantage of what we are talking about here, then I think this will bring us into that area.

MR. WHITNEY: Is there anything wrong with that?

MR. WALPOLE: No. I agree entirely.

MR. NAYLOR: I think that is enough on that particular point. I have one or two other questions. On page 13, as I understand your Section 41, you suggested the makeup of the Board of Directors of Medical Carriers Incorporated as

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particular point. I have one or two other questions. On page

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two members from the licensed insurance companies and five other members: One from the Co-Operatives, one from Cumba and one from each of the three doctor-sponsored plans; do you think that is a very fair representation?

MR. WALPOLE: I would have to answer, Mr. Chairman, Mr. Naylor's question in this fashion: I think considering the contracts in force, bodies covered, that this would be a fair representation. I do not agree that -- for the lack of a better word, let us call it thin coverage -- should carry the same weight as comprehensive coverage which provides for home and office care, for hospital care, for surgery, for maternity, and so on. And to come back to what I meant by thin coverage, a good example of that would be we had a number of years ago polio coverage and I do not think that we can mix these two together and call them either apples or oranges. They are two different breeds. So I think the coverage represented by these people, as we have set them forth here, fairly represents comparable coverage today.

MR. NAYLOR: One other question. On page 18, you suggest that it is unethical to collect premiums for the waiting period of three months, which would be applicable to persons applying after the initial enrolment period. I am not sure I understand your thinking there. It is true that while they have paid premiums for that period they couldn't collect any benefits; but, nevertheless, they are receiving a very

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MR. NAYLOR: One other question. On page 15, you suggest that it is unethical to collect premiums for the

persons applying after the initial enrolment period. I am not sure I understand your thinking there. It is true that while they have paid premiums for that period they couldn't collect any benefits; but, nevertheless, they are receiving a very

valuable concession in being permitted to take out a policy, to defer taking out a policy until they think they are going to need it. That is a real valuable privilege that we are giving. In fact, there may be some question as to whether we are charging them enough by simply charging them three months' premiums to offset the anit-selection. I was interested in knowing what your experience is. I gather, from some figures in the brief, that you do have your non-group policy that an individual can buy and that you have a fair number of persons covered under that. You have had it for a few years. I would be interested in knowing what you do to offset the anti-selection? Do you have a waiting period? Do you charge premiums only from the end of the waiting period? And what has your experience been in these individual risks, as compared to the group enrolment?

MR. WALPOLE: I will try to take that as much in the order as you have given it as possible. First of all, there is just one point in respect of the ethical part of this. There are only two things that we can purchase in this life. Those two things are goods and services. Let us take goods, for the moment. Suppose the housewife wishes a new washing machine and she goes down to the dealer and he says: "Yes, Mrs. X., this machine is $144.00. First of all, though, before you get the machine you pay me three payments. Then we deliver the machine and you start paying 12 payments of $12.00

a month, plus interest." I think we would take a very dim view of this. This is the basis on which we are making the statement that it is unethical to collect something for which we are not delivering either goods or services.

Now, our method of handling our non-group. We accept applications from the man on the street, without any restriction as to age or state of health, and this follows this schedule: A subscriber, a man or a woman, applies to us during the month of January -- any time during the month of January -- and he pays to us an enrolment fee of $2.00, plus the appropriate premium for one month, or two months or whatever he might desire to pay, and his coverage then becomes effective on the first day of May. If he pays one month's premium, that premium applies to the month of May.

MR. NAYLOR: Is that a five months' waiting period?

MR. WALPOLE: No. It is three clear calendar months. It can be stretched to almost four. If he applied on the 2nd of January, it is almost four.

Your other question was as to our experience. Our experience has been that this is a costly group. But this does not shake us too much when we have analyzed this particular enrolment. In this enrolment, we have a very high degree of the upper-age group, over age 65. It is about 25 or 26% of our total enrolment in that particular field and this is

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understandable when you look back over the years and find that carriers were reluctant to continue the coverage of those persons beyond age 65. In many instances, they were dropped like hot potatoes and we now have these persons coming into our enrolment in the high cost area and, naturally, this gives us a sharp incline in the curve in the cost picture.

MR. NAYLOR: Is it true that your premiums are not covering claims for that particular group, or do you wish to say?

MR. WALPOLE: I would rather reserve that.

MR. NAYLOR: Yes, fine.

THE CHAIRMAN: Mrs. Aylen?

MRS. AYLEN: Mr. Chairman, I would like to ask Mr. Walpole this. On page 22, recommendations, number 65, you recommend, I believe, that the annual or periodic health examinations should be a benefit. Do you have such a benefit in your plan?

MR. WALPOLE: Yes, we do.

MRS. AYLEN: Is it one or two times a year?

MR. WALPOLE: One in a twelve month period. Twelve months must elapse between examinations.

MRS. AYLEN: If a plan did not include that, do you think that it could be, the privilege could be sought under other means? Do you think that people could have those examinations under some other guise?

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MR. NAYLOR: Yes, fine.

THE CHAIRMAN: Mrs. Aylen?

MRS. AYLEN: Mr. Chairman, I would like to ask Mr. Walpole this. On page 15, recommendations, number 6 you recommend, I believe, that the annual examinations should be a benefit. Do you have such a benefit in your plan?

MR. WALPOLE: Yes, we do.

MRS. AYLEN: Is it once or two times a year?

MR. WALPOLE: Once in a twelve months period. Twelve months must elapse between examinations.

MRS. AYLEN: If a plan did not include that, do you think that it couldn't be, the privilege could be sought under other means? Do you think that people would have these examinations under some other guise?

MR. WALPOLE: Yes.

MRS. AYLEN: So you think it might be just as well to include them?

MR. WALPOLE: Yes, this is true.

MRS. AYLEN: On page 21, I was extremely interested in your formula there and, not being too familiar with insurance plans, can you tell me, as a layman, how you worked out that formula? I mean, is it in use at all?

MR. WALPOLE: Yes. The three rate structure is not an unusual rate structure. I do not know whether this answers your question or not, or are you referring to the exact formula that we have here in front of us?

MRS. AYLEN: Yes.

MR. WALPOLE: The "x", "2x" and "$2\frac{1}{2}$x". Is that correct?

THE CHAIRMAN: That is the one on page 21.

MRS. AYLEN: Yes.

MR. WALPOLE: I can go into that a little further. Let us use round figures here. Let us use four dollars for a single premium. We double that premium for a 2-person contract, which would be eight dollars and then we say two and a half times x, or two and a half times four dollars, would be ten dollars for the family. Now, this is not unusual because I think any of us who are acquainted with the cost curves in a pre-paid plan, or any insurance, for that

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unusual because I think any of us who are self-retired with

coat curves in a pre-paid plan, or any insurance, for that

matter, will find that in the first year of life it is a very expensive proposition and from there on up into the early teens it is relatively inexpensive, and on up even up into the late teens.

Then most carriers eliminate as a dependent those persons who have reached age 19; so in the early years their medical costs are relatively low, in comparison, to those in later years and this gives a break to those persons in the older age category who have no dependents, other than a man and wife, and they are paying only their premium for the two of them. For the parents, if the family are helping to carry theirs, if you carried this through to the ultimate, you would have a rate structure compounded many times over and above this, which was really not feasible.

MRS. AYLEN: Can I just come back to page 22 again. This is something that just came to me now. What percentage of your subscribers avail themselves of the ability to have periodic check-ups? Can you tell me that? I do not expect a one hundred per cent accurate answer.

MR. WALPOLE: About 11.4 persons per thousand covered, per month.

MRS. AYLEN: That does not include any diagnostic service?

MR. WALPOLE: No, this is the routine medical check-up. If there were additional diagnostic service -- that

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check-up. If there were additional diagnostic service -- that

is if the physician felt there should be an x-ray -- then that would be over and above that.

MRS. AYLEN: Even if it was in his own office, it would not be allowed?

MR. WALPOLE: If he were doing radiology, yes, it would be allowed.

MRS. AYLEN: It would be allowed?

MR. WALPOLE: Yes.

MRS. AYLEN: Thank you. That is all.

THE CHAIRMAN: Mr. Whitney?

MR. WHITNEY: I have just one question, Mr. Chairman. Mr. Walpole, on page 2 you discuss Schedule B and in your paragraphs 9 and 10, particularly in 9, you discuss the fall in enrolment under your plan from 1947 to 1959. Did you make a study of that block of business to know why this business did not get public acceptance so that you pretty much got out of it?

MR.WALPOLE: We found that at that time we were selling this small package, let us call it, limited type coverage, to groups of five or more and over a period of time our requirements for our comprehensive coverage changed. It was 25 and then it dropped to 15 and 10 and our experience was that at the moment a group reached that size where they could request coverage in a comprehensive medical plan, this is what they did; so that we could not bring enough in at the top to keep pace

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MRS. AYLEN: Even if it was in his own office,
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is if the physician felt there should be an x-ray -- then that

with the exodus at the bottom.

MR. WHITNEY: Your suggestion of deletion then is to have the Schedule B in-hospital medical services under Schedule A?

MR. WALPOLE: Yes. We are not against any carrier selling coverage the equivalent of Schedule B; but we do not think it should be in the Act as a standard plan.

Mr. Chairman, may I correct a statement I made previously?

THE CHAIRMAN: Yes.

MR. WALPOLE: I made the statement to Mrs. Aylen. I quoted an 11.4 figure and I was reading a line too high. It is 2.9.

THE CHAIRMAN: That is 2.9 per thousand, per month?

MR. WALPOLE: That is right.

THE CHAIRMAN: Do you have further questions, Mr. Whitney?

MR. WHITNEY: In this withdrawal from the Schedule B type plan that we have been discussing, did it seem to make any difference to you, in your experience, whether the premium was fully paid by the employer or partly paid both ways by employer and employee?

MR. WALPOLE: When this plan reached its maximum proportion in 1957, at that time there was very little employer

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MR. WALPOLE: When this plan received its maximum

proportion in 1957, at that time there was very little employee

participation. So I would say that that did not have too much effect on it and as time went on this became more and more prevalent with the employer participation in the cost. I wouldn't say it didn't have any effect; but I would say, from our experience in 1947, when it reached its maximum at that time, this type of agreement did not become prominent in this area. I am talking about labour-managements agreements now. It came prominent in this area in the early '50's. About 1952, I would say, this became -- came into vogue at that time and our coverage in our limited plan was slipping at that time. So I would say that this was not the deciding factor.

THE CHAIRMAN: Mr. Coulter?

MR. COULTER: I would like to know what the procedure is or how you can handle it where you have a person employed in a group, who has enjoyed group coverage for a number of years and he becomes of retirement age, 65; what happens to him? Can he still carry on under the group coverage of his former employer or does he have to buy an off-street program and, if so, is there any difference in the rate?

MR. WALPOLE: There are two avenues of pursuit here. One is, as far as we as a corporation are concerned, we do not require that this man be dropped from his employer's coverage. He may continue to enjoy the group rate and the group benefits as he did throughout his working years, provided his employer wil continue to keep him on his group. If the employer

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MR. GOULDEN: I would like to know what the procedure is or how can auxiliary it where you have employed in a group, who has enjoyed group coverage of years and he becomes of retirement age, 65; what to him? Can he still carry on under the group coverage former employer or does he have to buy an old-agency program and, if so, is there any difference in the rate?

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does not see fit to extent that privilege to his employee, then we allow him to continue his exact same coverage, without any loss of waiting periods, at a rate which is slightly above group rate, enough to pay for the extra administration costs involved in handling him as an individual, as opposed to a group.

THE CHAIRMAN: Are there any further questions, Mr. Whitney?

MR. WHITNEY: Not at the moment, Mr. Chairman.

THE CHAIRMAN: Dr. Galloway?

DR. GALLOWAY: I have two very unrelated questions that I would like to ask and it is slightly due to my ignorance of Medical Carriers Incorporated and its future activities. It would appear to me that there will be a considerable number of carriers who will be associated with this organization. It is undoubtedly true also that there will be a great variation in the amount of business that they do. It would seem that Carriers Incorporated will have to deal with the various amounts of business, or various companies and, yet, you have suggested a flat rate of payment for each of these and you have given your reason on page 14, paragraph 43. It is slightly due to my ignorance of this, but if you could clarify it I would appreciate it.

MR. WALPOLE: I will do my best to clarify our position in this respect. It was not visualized that Medical

does not see fit to extent that privilege to his employee, then we allow him to continue his exact same coverage, without any loss of waiting periods, at a rate which is slightly above group rate, enough to pay for the extra administration costs

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MR. WALPOLE: I will do my best to clarify our position in this respect. It was not visualized that Medical

Carriers Incorporated will ever become insuring agents themselves. They will never pay claimants. It will be, to put it in simple terms, a clearing-house. The carrier will report his gross figures, his statistics, as required by M.C.I., in order for them to put him in his proper niche or to relate his experience with that of all carriers. One of the duties of Medical Carriers Incorporated, which we have enunciated in our brief, will be to declare and regulate open enrolment periods. The open enrolment period, it is no more of a problem for Medical Carriers Incorporated to say that we will have an open enrolment period from October 1st to November 30th and P.S.I., which I believe is the largest single carrier in the Province of Ontario -- it is no greater chore for M.C.I. to say that than it is to say to the railway -- not the brotherhood -- the gentlemen who were here this morning, the nine hundred persons -- it is still from October 1st to November 30th. This is a rather simple way of putting it. There are other considerations. When you get into the dollar value and each carrier will report through his total and when you get into a pooling arrangement, his total claims cost for these persons who are pooled, and the only difference between the fellow with the nine hundred and the fellow with a million will be the number of digits to the left of the decimal point. So, basically, they are doing the same thing for both, or at least, M.C.I. is.

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MR. WALPOLE: Pardon?

MR. COULTER: Did you have any formula to produce this flat rate?

MR. WALPOLE: Well, I would have to say this: I do not think anyone, to my knowledge, has any idea of the expenses involved in the operation of M.C.I. until it becomes an operating unit.

MR. WALPOLE: Pardon?

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DR. GALLOWAY: Could you give us a guess as to whether such an organization as was here this morning, the Railroad Hospital Association, would such an organization be able to pay on the same basis as P.S.I.?

MR. WALPOLE: Well, again, we get back to what the value of X would be, what we are going to apportion out.

Let's take a very simple proposition here, and let's say that it's going to cost an organization $600. That's $2 a year for each person they have got covered. I'm sorry, I'm getting ahead of myself. If they're going to pay $600, they have to charge 50 cents a year if they have 1,200 people there, and if you average that over a per-month cost, it isn't going to be too hard on the small carrier. But we don't know what X is going to be, and that's one of the reasons why I can't give you a straightforward answer on it, sir.

DR. GALLOWAY: Thank you very much. I have another question, which is completely unrelated, but it does have to do with the briefs which have already been presented to us, one from the podiatrists, and one from the chiropractors, each of whom have requested that their services be insured under whatever plan is introduced by government.

In the event that these services became insurable under the standard plan, could you, as an Association, insure them, and if you could, what problems would it create for you?

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MR. WALPOLE: May I sort of break your question down just a little?

First, you can't add any item of service, or extend benefits in any way, shape or form, without incurring additional costs. This is something that just doesn't happen. So, immediately you introduce something like this, you introduce an element of cost.

This is one problem which would be created. Then, if we were to embrace these other services which aren't currently covered, and honestly I would have to think a little further along those lines to really give you an answer as to the problems that might be involved in covering those two.

DR. GALLOWAY: Well, one of the things that you might be able to answer is, would this require any change in your charter?

MR. WALPOLE: Yes, it would. As far as we are concerned it would require a change in our agreements, because at the moment we're precluded from paying anything other than the services of a legally-qualified medical practitioner under The Medical Act.

DR. GALLOWAY: Thank you very much.

MR. CASWELL: Mr.Chairman, I'd like Mr. Walpole, to ask you one question further on page 22, Section 65, which has already been spoken to.

I think that I agree with you that an annual

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DR. GALLOWAY: Thank you very much.

MR. CASWELL: Mr.Chairman, I'd like Mr. Walpole, to ask you one question further on page 22, Section 65, which has already been spoken to.

I think that I agree with you that an annual

health examination, in the long term, would be good for the patient, as well as, perhaps, the Medical Association. I'm interested in knowing whether you believe, first of all, that the medical profession could cope with an annual health examination, if everyone were covered with health services?

MR. WALPOLE: Mr. Chairman, I would like to refer that question to one of my confreres here, and I would ask our President if he would take that question.

THE CHAIRMAN: Granted.

DR. DUROCHER: Well, I think in answer to that question, in terms of my own experience here, where you have quite a large segment of the population covered, and the medical profession here is coping ---

MR. CASWELL: I thought you suggested that only 2.9 persons per thousand per month were having this periodic inspection, which seems to be quite a small number, is it not, in your case?

If this were included in the Act, I would assume from the very fact that you brought it up that you would recommend that this be a condition of coverage, that everyone would, as a condition of their contract, have an annual examination?

DR. DUROCHER: That seems to be the general fear, but our own experience doesn't show it.

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MR. CASWELL: You mean you don't make it

conditional to the contract?

DR. DUROCHER: No.

MR. CASWELL: But are you not suggesting such a thing?

MR. WALPOLE: All we're suggesting here, sir, is that this would be a benefit. We're not suggesting that it would be a compulsory examination. It would be a benefit, the same as an appendectomy.

MR. CASWELL: If it is good, and this Act is for the good of humanity, why should it not be covered?

MR. WALPOLE: Well, there are several Acts that you could apply that same criterion to, and I would hate to see one phase of medical services become a compulsory item when, perhaps, you could be just as justified in making some other area of medical services compulsory.

MR. CASWELL: Then by including this you're only going to give the benefit to the very small percentage who would take advantage of it?

MR. WALPOLE: I might clarify that in this respect. In our organization we have included periodic health examinations. As I explained earlier, each person covered in our plan, after he has fulfilled the initial waiting periods, is eligible for medical examination every twelve months, or at least there must be a twelve-month lapse between the examinations.

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Now, if he is receiving regular medical care from his doctor, then he's not eligible for it. At least, we do not pay the physician for that, because this is not preventive medicine.

MR. WHITNEY: Do you have salesmen in the field?

MR. WALPOLE: We've had two until very recently, and we only have one now.

THE CHAIRMAN: Does that complete your questioning, Mr. Caswell?

MR. CASWELL: Thank you, sir.

THE CHAIRMAN: Mr. Simon?

MR. SIMON: On page 1, Mr. Walpole, you speak about "off-the-street" enrolment, or the non-group enrolment.

Do you charge these people a different premium than you do the groups?

MR. WALPOLE: Yes.

MR. SIMON: You do?

MR. WALPOLE: Yes.

MR. SIMON: Is it much higher?

MR. WALPOLE: To give you an exact figure on that, the single rate with group is $3.25 to a person per month, and the pay direct, that is the group conversion, is $3.60, and the non-group is $3.85.

MR. SIMON: On page 5, paragraph 18, you're making recommendations that the Act be changed to read that

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MR. SIMON: On page 5, paragraph 18, you're making recommendations that the Act be changed to read that

people that have mis-used the services be denied coverage, and so on.

How can any person mis-use the services without a doctor being involved in it?

MR. WALPOLE: I think that's very easily explained, sir. We have in our experience on a couple of different occasions found a particular individual who was seeing three doctors, three general practitioners, in one day for no particular ailment at all.

I think this is a real abuse of service.

MR. SIMON: Do you get that in Toronto?

MR. WALPOLE: I don't think we would want to inflate the cost of medical care in this province by allowing that to continue.

MR. SIMON: Wouldn't you say that the wording, the way you have it, can be widely interpreted, misinterpreted?

MR. WALPOLE: I would like to point out that we have used the words:

"---or proven continued mis-use of services---"

I could subscribe that that particular individual might have on occasion found it necessary to visit two doctors on the one day. Perhaps one doctor wasn't available for some reason or other, but we've put in the word "continued" here, and simply because it happens once doesn't mean it's a mis-use of services, but if this thing persists, I think you have a

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MR. WHITNEY: Is it in your contract now, this mis-use of service?

MR. WALPOLE: Not as such, no, but we do have the right within our agreement to terminate the coverage of any individual.

MR. SIMON: On page 21 you're making suggestions with regards to the set-up of arbitration with regard to the difference of rates and so on. You are still suggesting that two of the representatives of the Board of Arbitration be from the carriers in different categories, and one be an impartial representative named by a judge from the Supreme Court.

Now, where, in your view, does the public come in, that has to pay the bill after all, on the set-up of the determination of what is to be a proper rate?

MR. WALPOLE: Well, I would say that this applies only to the maximum subscription rate, and the vast majority of the public will never be involved in it.

MR. SIMON: Somebody told us this morning that eventually everybody will be paying the maximum subscription.

MR. WALPOLE: Well, I would only have to say that perhaps that individual expressed an individual point of view, and I express my own, that this will not be affected.

MR. SIMON: You talk about comprehensive

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MR. SIMON: You talk about comprehensive

coverage, and I'd like to know if your organization has ever made a survey in the area here about what actually it does cost a family to cover all their insurance, other than what you provide for them?

MR. WALPOLE: No, we've never made such a survey.

THE CHAIRMAN: Do any other members of the Enquiry have questions that they wish to direct to this delegation?

DR. BUTT: On the constitution of Medical Carriers Incorporated, as you heard this morning, there are several other organizations, and probably a number of others who might want representation, and as I read it, there's no provision for that.

MR. WALPOLE: In what we've set up for the moment for Medical Carriers Incorporated?

DR. BUTT: Yes; and the other question related to it today. This is just another little formula, and you say two from the insurers, one P.S.I., one W.M.S., and one from the others.

Is this a compatible group? In other words, your Medical Carriers Incorporated becomes a five-man group? This is on page 13, Section 41.

MR. WALPOLE: Is that not seven?

DR. BUTT: No. Two from carriers, one P.S.I., being the heaviest, and one W.M.S., whether they are

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DR. HUTT: No. Two from carriers, one P.S.I., being the heavies, and one W.M.S., whether they are

compatible or not together, and then all the others. I think this works out relatively covering the same number, so that's five.

I'm just suggesting a possible formula, whether this would be good, bad, or indifferent.

Would that meet with your approval at all?

MR. WALPOLE: You're suggesting five instead of seven. Is this correct?

DR. BUTT: That's right, with that make-up.

MR. WALPOLE: And your question, again, is would this tend to improve the situation?

DR. BUTT: Would it be satisfactory to you?

MR. WALPOLE: No, I don't think so. I think that our feeling is that it should be just the way it's in here.

DR. BUTT: On page 22, Section 63, does this produce the responsibility, and I'm not quite sure at the moment, the responsibility would be somewhat on the carriers as to whether there's double coverage or not, and you want it reworded so that the responsibility lies with the individual?

MR. WALPOLE: That's right.

DR. BUTT: Well, what happens if he was mistakenly sold two or three policies? In other words, he might buy them in good faith. I don't know why, but he might. He might be sold them in good faith.

compatible or not together, and then all the others. I think this works out relatively covering the same number, so there's five.

I'm just suggesting a possible formula, whether this would be good, bad, or indifferent.

MR. WALPOLE: You're suggesting five instead of seven. Is this correct?

DR. BUTT:

MR. WALPOLE: And your question, again, is would this tend to improve the situation?

DR. BUTT: Would it be satisfactory to you?

MR. WALPOLE: No, I don't think so. I think that our feeling is that it should be just the way it's in here.

DR. BUTT: On page 52, Section 63, does this produce the responsibility, and I'm not quite sure at the moment, the responsibility would be somewhat on the carriers as to whether there's double coverage or not, and you want it removed so that the responsibility lies with the individual?

DR. EWETT: Well, what happens if he was mistakenly sold two or three policies? In other words, he might buy them in good faith. I don't know why, but he might. We might be sold them in good faith

MR. WALPOLE: As I recall Section 20 of the Act here, I believe the first policy registered is the one that takes precedent, I believe, if I recall it, and that's the only way I could see to get out of that.

Now, we're not lawyers, and we did not have legal opinion on this particular section of the Act. All we desired to do was to point out a problem here, which I believe only the legal profession can resolve, as to putting it into the correct wording, and we're just pointing out the problem.

DR. BUTT: Yes. Well, I realize the problem. I was trying to shift it back on the companies, instead of on the poor individual subscriber who might be gypped out.

MR. MULROONEY: W.M.S. covers a good proportion of the residents of Windsor and its suburbs. I'm wondering whether its coverage provides full payment for the services? Is the doctor permitted to charge in excess of the payments made by W.M.S.?

MR. WALPOLE: Mr. Chairman, this is a very interesting point. Windsor Medical Services has closed-end agreements with its participating physicians, and the only time a physician is allowed to extra-bill over and above the payment he receives through the Windsor Medical Services is in those areas where the annual income of that particular subscriber exceeds the income limits, which are $7,000 annual income single, and $10,000 annual income married.

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MR. MULROONEY: On page 4, in your recommendation with regard to the definition of "benefit," you ask for the addition of the words "or on behalf of."

I wonder if this could not be satisfactorily handled in the contract that is issued to the applicant, provide for it there, and whether it's necessary to make any amendment?

MR. WALPOLE: We have a lot of these in our general population, curbstone lawyers, and if they got this Act they would sure wave it in front of you and say, "This means that this payment can't be made to anyone else except me," and service plans, of which Windsor Medical is one, we've traditionally made our payment direct to the doctor, and this gives us our opportunity to do that, to make payment on behalf of a covered person directly to his physician.

MR. MULROONEY: I've no further questions. That's the answer I expected.

MRS. AYLEN: In a city such as this you must have people who become unemployed while they are subscribers to your plan, and they might find it necessary to let their subscription lapse.

Is there any machinery set up to aid them?

MR. WALPOLE: Yes. First of all, let me deal with the person in this area, in this particular area, under negotiated contracts through employer and employee negotiation,

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MR. WALPOLE: Yes. First of all, let me deal

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and many of these contracts now provide that this may be continued by the employer for a period of time, the month in which layoff takes place, for any period of time up to three months, and then he may - and I might say we have had instances where it has gone beyond that, it has gone beyond the contractual obligation, then he may elect to pay the employer the group rate to get advantage of the lower rate, and he will again remit through to us.

Now, this takes care of the chap who is laid off by an employer who has a negotiated contract.

The chap who doesn't have a negotiated contract, and have these inherent benefits, the only thing we can offer to him is a pay-direct agreement, and, of course, we can't provide coverage for anyone without receiving money for that particular month, but we do have a policy where if for some reason such as you outline a person very reluctantly is called upon to drop the coverage due to financial embarrassment, that if they apply to us within a six-month period -- we don't reinstate the contract, but we will give them a new contract without having to go back through the non-group agreement, and so on, such as they had before.

MR. MAJOR: Mr. Walpole, on page 4, you have referred to dependants, and it would appear to me that you've left out a couple of points that I would like to clarify.

You say that a dependant shall be "a son or

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MR. MALONE: Mr. Walpole, on page 4, you have

referred to dependants, and it would appear to me that you've

left out a couple of points that I would like to clarify.

You say that a dependant shall be "a son or

daughter, or stepson or stepdaughter of the head of a family--"

Can you tell me what you are going to do, or how you're going to handle a grandchild, who's only visible support is grandfather?

MR. WALPOLE: Well, first I would like to go back to the wording of the Bill 163 in this particular section, and Section 1, sub-section (d), sub-sub-section (ii):

"any unmarried child under the age of 19 years who is dependent or substantially dependent for maintenance upon the head of a family."

Now, it seems to me that this is a pretty broad platform on which to start to make a decision. It says:

"any unmarried child ---"

It doesn't say whether it's related, unrelated or not - "any unmarried child," a neighbour's, or anybody's else.

So we feel this must be taken care of by a change, and the change we've reflected in our submission here, and our thinking ran along these lines. It's much easier to write this on a reasonably tight basis, and administrate on those individual cases such as you outlined, and I don't mean this in a true sense, but administrate on a loose basis, rather than write it on a loose basis and try to administer it tightly.

MR. SIMON: I thought you told us before that

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MR. SIMON: I thought you told us before that

you weren't lawyers.

MR. WALPOLE: Thank you.

MR. MAJOR: I understand what you're getting at, but I'm not too sure that the Government, the politician will accept this nebulous area of give, rather than take away.

Now, what are you going to do about this child who is 29 years of age, and can't work because of physical infirmity, where it says in the sub-paragraph (iii) of (d) -- are you just going to eliminate this fellow, too?

MR. WALPOLE: No, we have him covered over on page 5, under sub-section (b).

Did I understand you to say 29 years of age?

MR. MAJOR: Yes.

MR. WALPOLE: Well, if he was 19 years of age, or older, mentally or physically infirm, and dependent for support on the head of the family or upon the spouse of the head of the family before his 19th birthday but that does not include the spouse or dependants of any such child.

MR. MULROONEY: May I observe, Mr. Chairman, that such a person would probably qualify for the disabled persons' allowance, and should be a government responsibility then.

THE CHAIRMAN: Remember that we're not debating this issue.

MR. MAJOR: Mr. Walpole, on page 8 you are

you weren't lawyers.

MR. WALPOLE: Thank you.

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THE CHAIRMAN: Remember that we're not debating this issue.

MR. MAJOR: Mr. Walpole, on page 8 you are

referring to Section 4 of the Act, and the only change I see is that you have eliminated the wording "or standard in-hospital medical --" but I'd like to ask you about the wording "a local municipality may."

Do you think it's proper that a municipality should have an election in this issue?

MR. WALPOLE: If I might just ask for a little clarification, Mr. Major. What you're saying, if I interpret it correctly, is, should a municipality have the right to say, "We will pay the medical costs of this particular indigent if those costs are likely to be less than the premium which we would pay if we covered him under this type of program."

MR. MAJOR: That's right. I'm asking the question, Mr. Walpole, because we've had several references to anti-selection.

MR. WALPOLE: Will you pardon me just one moment while I read the previous ---

I'd say that Mr. Major has put his finger on a good point here, that this could leave itself open to an abuse by anti-selection. It might well be that the municipality shouldn't have that option.

I think, looking at it now I would say that.

MR. MAJOR: Mr. Walpole, on page 13, I was very interested in a recommendation you set forth here:

"We recommend that each director be a

medical --" but I'd like to ask you about the wording "a local municipality may."

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MR. MAJOR: Mr. Walpole, on page 13, I was very interested in a recommendation you set forth here:

"We recommend that each director be a

permanent resident of the Province of Ontario."

Supposing that we had a very knowledgeable chap on medical economics living in Montreal, but that from a technical standpoint it would be very desirable to have him on this Board; would you want to eliminate the privilege of having this chap on this Board?

MR. WALPOLE: If this chap is a very knowledgeable chap living in the City of Montreal, or anywhere else, for that matter, I think we could even go beyond that. Let's go to another country. If he is that valuable, I am sure that a representative on this Board could seek his advice on a particular problem, and it would still -- his wealth of knowledge could still be utilized in that particular field, and yet we would be keeping this within the confines of the Province of Ontario, because this is an Act developed by the Province of Ontario for the citizens of this particular province, and simply because this chap lives outside of the province doesn't preclude us from seeking advice from that particular individual.

MR. MAJOR: In other words, you would use him as a consultant?

MR. WALPOLE: That's right.

MR. MAJOR: But you wouldn't necessarily shoulder him with a responsibility that he isn't living with, as it were?

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MR. WALPOLE: That's true.

MISS McARTHUR: I'm wondering if there have been any problems regarding the care of the newborn, and whether the problem has necessitated the writing of regulations thereon, or has it not been a problem at all?

MR. WALPOLE: We do cover newborn care.

DR. ROEMMELE: I don't exactly understand the question, Mr. Chairman. Newborn care is covered in our contract, a certain number of visits are outlined that they are eligible for.

MISS McARTHUR: I was referring to page 26, removing the examination from the Act and leaving it to be controlled by the O.M.A. Schedule, and in addition to that having had to write regulations.

MR. WALPOLE: We have certain limits on well-baby care visits, and this particular examination which we have mentioned here should be controlled by the fee schedule. This is really a benefit. It isn't something which should be in the Act.

MR. SIMON: What proportion of the doctors in this area are participants in the Windsor Medical Services?

MR. WALPOLE: About 98%, sir.

MR. SIMON: In case of a strike at one of the companies that has insurance with your people, do you allow the union to pay the premiums for the group?

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MR. SIMON: In case of a strike at one of the

companies that has insurance with your people, do you allow

the union to pay the premiums for the group?

MR. WALPOLE: Yes, they pay it through the company, so that all persons -- there are certain classifications of employees not considered to be on strike, and they'll be covered, but our arrangement has been in the past that the union pays through the company.

MR. SIMON: And no one loses any benefit?

MR. WHITNEY: Do you allow any grace period before you terminate, or lapse a contract for non-payment of premium?

MR. WALPOLE: Yes, first of all those persons terminating from a group have a 30-day period in which to pick up their pay-direct agreement.

MR. WHITNEY: Thirty clear days?

MR. WALPOLE: Yes, 30 days from the end of the paid-up period on the group. They have 30 days to pick up their pay-direct agreement, or the group conversion.

Then those persons billed on non-direct, or pay-direct agreement are billed roughly on the 20th of the month, or the due date of the first of the following month, but we continue to carry those people along till the last day of that month. In other words, they have 30, 31 days of grace.

MR. WHITNEY: Do you send out a notice of termination?

MR. WALPOLE: No, it's done, or I should say, yes, we do, to a degree.

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MR. WHITNEY: That's included in the double-billing?

MR. WALPOLE: That's right. So that in effect everyone gets notice.

MR. WHITNEY: How about reinstatement? If the individual doesn't pay his premium for some period of one, two or three months, do you allow reinstatement, or is it a new application? Do you have any clause in your contract?

MR. WALPOLE: No, there's no clause in the contract. This is administered by administration on the basis of there are extenuating circumstances in a number of cases, and these are reviewed, and if the case warrants reinstatement, or full reinstatement of all benefits, then that is done. If it doesn't, then they are offered a new course.

MR. WHITNEY: Do you have rules and regulations as to when you will exercise your discretion, and how?

MR. WALPOLE: I don't quite follow your question.

MR. WHITNEY: Well, this is a discretionary

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MR. WHITNEY: Well, this is a discretionary

power you are exercising?

MR. WALPOLE: Yes.

MR. WHITNEY: And I imagine the power is vested in a committee of your organization?

MR. WALPOLE: Yes, and this can go right on up to our Board of Directors.

MR. WHITNEY: Do you have any written bylaws, or rules and regulations, as to when you consider it is a deserving case, and when non-deserving?

MR. WALPOLE: Not as written law, no.

MR. WHITNEY: Do you make your payment having the bill from the doctor rendered direct to you, or do you have the patient fill out a form?

MR. WALPOLE: No, the doctor renders his account directly to Windsor Medical Services.

MR. WHITNEY: Is there anything in your contract, or in what you have your medical doctor membership supply in the way of a bill with -- I think it would be in the contract, really. Is there anything in your contract of these words "on behalf of" that we've been talking about, stating that you have the right to pay to the doctor on behalf of the insured?

MR. WALPOLE: It's implied in here. It's really in reverse. It is only when the subscriber is travelling on vacation, or business, that we make any agreement to

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MR. WHITNEY: To the subscriber?

MR. WALPOLE: That's right.

MR. WHITNEY: These words you are suggesting might usefully go into the Act. Do you have any such words in your contract?

MR. WALPOLE: No.

MR. MAJOR: Mr. Walpole, it's common in some insurance contracts to insert words of this kind: "That non-payment is automatic cancellation of this agreement."

Do you exercise this? You've told us that you send out two or three notices, but when you are finished with that, and this is done, this is a cancellation because they didn't pay the bill?

MR. WALPOLE: That's right. "Failure to pay the subscription rates applicable shall entitle the corporation to automatically terminate the provisions of the agreement created hereby and any benefits accruing thereunder and it is specifically declared that time shall be of the essence of the provision for payment of all such subscription rates."

6 MR. MAJOR: Have you provision in your agreement of appellate authority that a subscriber can appeal to, other than you as General Manager, or as Administrator?

MR. WALPOLE: Yes, it's not in the agreement that he can appeal to the Board of Directors.

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MR. WALPOLE: Yes, it's not in the agreement that he can appeal to the Board of Directors.

MR. MAJOR: Is it in your charter?

MR. WALPOLE: It's not in the charter either, but this is one of those things which has become a part of our way of life, that anyone can appeal to the highest authority within our organization, which is our Board of Directors.

MR. MAJOR: Considering Bill 163 in toto, would you accept the statement that this Bill will expect a carrier to recognize psychiatric services without limit?

MR. WALPOLE: I think this is definitely implied in Schedule A.

MR. MAJOR: You think this is a reasonable thing for this Bill to require?

MR. WALPOLE: In terms of dollars, I think this is going to lead us into a very inflationary aspect of medical care, if we are called upon to pay psychiatric services in toto, which are now being performed in provincially-administered hospitals, with psychiatrists working in those hospitals, who aren't working on a fee-for-service basis, and to suddenly throw this load into the arena of Bill 163 I think can only ask for chaos from the dollar standpoint.

MR. MAJOR: This, of course, will be quite a discussion in this Enquiry some day.

You have made no recommendation regarding this aspect of this Bill in your submission. Would you help us out now by giving us your opinion as to whether or not it would be

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MR. MAJOR: That's, of course, will be quite a discussion in this Enquiry some day.

You have made no recommendation regarding this aspect of this Bill in your submission. Would you help us out now by giving us your opinion as to whether or not it would be

reasonable to at least consider the launching of this Bill with a limitation for psychiatric care?

MR. WALPOLE: Yes, I think this Bill could be enlarged to embrace a certain amount of psychiatric care rendered on a fee-for-service basis, but I think, in order to avoid the chaos which I mentioned earlier, that this would have to be limited to a specific number of treatments, or number of hours' care in a given period of time, and if we're to take the data supplied by the psychiatric section of the organized medicine it would seem that 50 hours per year, I believe, if I recall the figures correctly, they thought would amount to somewhat in the neighbourhood of twelve million dollars a year, and this is a sizeable chunk of money for a limited program.

So, I can only say if we apply this for a limited program, where would it leave us on a wide-open program?

MR. MAJOR: Thank you. If you will refer to Schedule A, the exceptions. Annual periodic health examinations, under 1. Under 5, it says:

> "Services with respect to conditions that do not interfere with the covered person's bodily functions, or with respect to treatment for cosmetic purposes."

Now, considering these, would you say that this Bill included well-baby care?

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Now, considering these, would you say that this Bill included well-baby care?

MR. WALPOLE: I would say you could interpret "annual or periodic health examinations," if you so desired, as well-baby care, or at least interpret well-baby care as a periodic health examination. It might be once a month, but it could be interpreted to that exception, and again, as you point out in 5:

> "Services with respect to conditions that do not interfere with the covered person's bodily functions, or with respect to treatment for cosmetic purposes."

Well-baby care, again, could be excluded under the first part of No. 5.

MR. MAJOR: Well, I'm struck by the paradox, Mr. Walpole, that you have suggested in your submission that we have well-adult care, because that is what a periodic physical examination is, this is well-adult care, but you haven't commented as to whether or not we should have well-baby care.

MR. WALPOLE: Well, I think, Mr. Chairman, in reply to Mr. Major's supposition there, I think he has read into our submission something which really it didn't contain.

We said that there should be annual or periodic health examinations, which could be interpreted to mean well-baby care, but we have not applied the connotation "adult" to it.

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MR. MAJOR: Well, let me go one step further, then, and I know this is not in your submission, but we're interested in these kinds of things.

Supposing that it's decided that well-baby care is a normal benefit of this agreement, which, in my opinion, and it's got nothing to do with the Enquiry, it is not, because of these exceptions and the way they are written, and no submission we have dealt with yet has brought this point out, but supposing that this does become a benefit of this agreement, with maybe some help from the professional people, it is my opinion that a baby includes the years of from the time it is born till the time it is 14, I believe.

If this agreement is going to cover well-baby care, would you consider that well-baby care should go through 14 years of life; the first 14?

DR. ROEMMELE: Mr. Chairman, Mr. Walpole has asked me to answer this. I don't know exactly what Mr. Major is driving at. We call well-baby care up to a year, and after a year they are infants, and children, and, as you know very well, once your medical does cover well-baby care there's a certain stipulated number of visits in the first and each succeeding years, and we do allow an annual examination on a child at a little less rate than on an adult, and we certainly did not imply to exclude well-baby care from our recommendations.

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This is something that none of us thought anyone would read into it. In our recommendations we certainly mean to imply that well-baby care should be part of the standard medical services contract.

MR. MAJOR: Thank you. That's the point I wanted to bring out.

DR. GALLOWAY: These questions have been so interesting. Mine is a very minor and almost likely not one that should be delivered here. It so happens that if this Act goes through, the double coverage won't be allowed and it may not be as true in this area because there is only one major insurance company and that is Windsor Medical Services. However, in other areas there are men and women working in different institutions, one of whom will be covered by one insuring company and another by another company. What will you do about the premiums for the individuals who are under a group coverage on this basis?

MR. WALPOLE: I do not think that we can get into an area which is, perhaps, a negotiated contract between employer and employee and expect to be able to write an Act or write regulations that will govern all these things. So, in my humble opinion, these people are going to have to get together some way or other and get double coverage on there. That might sound sort of a confused statement. But we do encounter double coverage in this area, somewhat on the basis

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which you outlined, and employers have gotten together and ironed this thing out. And I see no reason why we should set up machineryto take care of something which is a Frankenstein in your own name.

MR. WHITNEY: Do you allow double coverage in your contracts?

MR. WALPOLE: Yes.

MR. SIMON: Do you allow portability from one group to another within your own organization? I refer to waiting periods?

MR. WALPOLE: Yes. They never lose their waiting periods, provided that they have paid premiums. The continuity of premium is what provides continuity of coverage; so they might transfer from a group to a pay contract and to a group and to another group and still retain their original waiting period.

THE CHAIRMAN: Are there any further questions? Mr. Walpole, can you leave with our Secretary a copy of your brief?

MR. WALPOLE: Yes.

THE CHAIRMAN: And if there is any other information that you have which you think might be of interest to the Enquiry, I am quite confident that they would appreciate having it. Thank you very much. I think you have made a very major contribution to the work of the Enquiry Committee.

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MR. MULROONEY: I think the Enquiry might be interested in knowing precisely the area that is covered by Windsor Medical Services. Do you operate in Essex County?

MR. WALPOLE: Yes. The geographical area in which we operate are the Counties of Essex and Kent in the Province of Ontario, embracing some 347,000 people.

THE CHAIRMAN: Members of the Enquiry, just a couple of brief items of business. We have had very fine accommodation here in these council chambers. I think it might be in order for a motion to be made formally that the Secretary extend our thanks to the Mayor and the City Council.

DR. BUTT: I will so move.

---Whereupon the hearing was adjourned at 3:50 p.m.

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